

PRELIMINARY DRAFT

TEXAS LEGISLATIVE COUNCIL  
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Chapter 544  
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25 CHAPTER 544. FRAUD, WASTE, ABUSE, AND OVERCHARGES RELATING TO  
26 HEALTH AND HUMAN SERVICES

27 SUBCHAPTER A. GENERAL PROVISIONS

28 Revised Law

29 Sec. 544.0001. DEFINITIONS. In this chapter:

30 (1) "Abuse" means:

31 (A) a practice a provider engages in that is  
32 inconsistent with sound fiscal, business, or medical practices and  
33 that results in:

34 (i) an unnecessary cost to Medicaid; or

1 (ii) reimbursement for services that are  
2 not medically necessary or that fail to meet professionally  
3 recognized standards for health care; or

4 (B) a practice a recipient engages in that  
5 results in an unnecessary cost to Medicaid.

6 (2) "Allegation of fraud" means an allegation of  
7 Medicaid fraud the commission receives from any source that has not  
8 been verified by this state, including an allegation based on:

9 (A) a fraud hotline complaint;

10 (B) claims data mining;

11 (C) data analysis processes; or

12 (D) a pattern identified through provider  
13 audits, civil false claims cases, or law enforcement  
14 investigations.

15 (3) "Credible allegation of fraud" means an allegation  
16 of fraud that has been verified by this state. An allegation is  
17 considered credible when the commission has:

18 (A) verified that the allegation has indicia of  
19 reliability; and

20 (B) carefully reviewed all allegations, facts,  
21 and evidence and acts judiciously on a case-by-case basis.

22 (4) "Fraud" means an intentional deception or  
23 misrepresentation a person makes with the knowledge that the  
24 deception or misrepresentation could result in an unauthorized  
25 benefit to that person or another person. The term does not include  
26 unintentional technical, clerical, or administrative errors.

27 (5) "Furnished" refers to the provision of items or  
28 services directly by or under the direct supervision of, or the  
29 ordering of items or services by:

30 (A) a practitioner or other individual acting as  
31 an employee or in the individual's own capacity;

32 (B) a provider; or

33 (C) another supplier of services, excluding  
34 services ordered by one party but billed for and provided by or

1 under the supervision of another.

2 (6) "Inspector general" means the inspector general  
3 the governor appoints under Section 544.0101.

4 (7) "Office of inspector general" means the  
5 commission's office of inspector general.

6 (8) "Payment hold" means the temporary denial of  
7 Medicaid reimbursement for items or services a specified provider  
8 furnished.

9 (9) "Physician" includes:

10 (A) an individual licensed to practice medicine  
11 in this state;

12 (B) a professional association composed solely  
13 of physicians;

14 (C) a partnership composed solely of physicians;

15 (D) a single legal entity authorized to practice  
16 medicine that is owned by two or more physicians; and

17 (E) a nonprofit health corporation certified by  
18 the Texas Medical Board under Chapter 162, Occupations Code.

19 (10) "Practitioner" means a physician or other  
20 individual licensed under state law to practice the individual's  
21 profession.

22 (11) "Program exclusion" means the suspension of a  
23 provider's authorization under Medicaid to request reimbursement  
24 for items or services the provider furnished.

25 (12) Except as otherwise provided by this chapter,  
26 "provider" means a person that was or is approved by the commission  
27 to:

28 (A) provide Medicaid services under a contract or  
29 provider agreement with the commission; or

30 (B) provide third-party billing vendor services  
31 under a contract or provider agreement with the commission. (Gov.  
32 Code, Sec. 531.1011; New.)

33 Source Law

34 Sec. 531.1011. DEFINITIONS. For purposes of

1 this subchapter:

2 (1) "Abuse" means:

3 (A) a practice by a provider that is  
4 inconsistent with sound fiscal, business, or medical  
5 practices and that results in:

6 (i) an unnecessary cost to  
7 Medicaid; or

8 (ii) the reimbursement of  
9 services that are not medically necessary or that fail  
10 to meet professionally recognized standards for health  
11 care; or

12 (B) a practice by a recipient that  
13 results in an unnecessary cost to Medicaid.

14 (2) "Allegation of fraud" means an  
15 allegation of Medicaid fraud received by the  
16 commission from any source that has not been verified  
17 by the state, including an allegation based on:

18 (A) a fraud hotline complaint;

19 (B) claims data mining;

20 (C) data analysis processes; or

21 (D) a pattern identified through  
22 provider audits, civil false claims cases, or law  
23 enforcement investigations.

24 (3) "Credible allegation of fraud" means  
25 an allegation of fraud that has been verified by the  
26 state. An allegation is considered to be credible when  
27 the commission has:

28 (A) verified that the allegation has  
29 indicia of reliability; and

30 (B) reviewed all allegations, facts,  
31 and evidence carefully and acts judiciously on a  
32 case-by-case basis.

33 (4) "Fraud" means an intentional deception  
34 or misrepresentation made by a person with the  
35 knowledge that the deception could result in some  
36 unauthorized benefit to that person or some other  
37 person. The term does not include unintentional  
38 technical, clerical, or administrative errors.

39 (5) "Furnished" refers to items or  
40 services provided directly by, or under the direct  
41 supervision of, or ordered by a practitioner or other  
42 individual (either as an employee or in the  
43 individual's own capacity), a provider, or other  
44 supplier of services, excluding services ordered by  
45 one party but billed for and provided by or under the  
46 supervision of another.

47 (6) "Payment hold" means the temporary  
48 denial of reimbursement under Medicaid for items or  
49 services furnished by a specified provider.

50 (7) "Physician" includes an individual  
51 licensed to practice medicine in this state, a  
52 professional association composed solely of  
53 physicians, a partnership composed solely of  
54 physicians, a single legal entity authorized to  
55 practice medicine owned by two or more physicians, and  
56 a nonprofit health corporation certified by the Texas  
57 Medical Board under Chapter 162, Occupations Code.

58 (8) "Practitioner" means a physician or  
59 other individual licensed under state law to practice  
60 the individual's profession.

61 (9) "Program exclusion" means the  
62 suspension of a provider from being authorized under  
63 Medicaid to request reimbursement of items or services  
64 furnished by that specific provider.

65 (10) "Provider" means a person, firm,  
66 partnership, corporation, agency, association,  
67 institution, or other entity that was or is approved by  
68 the commission to:

1 (A) provide Medicaid services under a  
2 contract or provider agreement with the commission; or  
3 (B) provide third-party billing  
4 vendor services under a contract or provider agreement  
5 with the commission.

6 Revisor's Note

7 (1) Section 531.1011, Government Code, defines  
8 terms for purposes of "this subchapter," meaning  
9 Subchapter C, Chapter 531, Government Code. Subchapter  
10 C is substantially revised in this chapter. The  
11 revised law in this chapter also includes the revision  
12 of Section 531.0215, Government Code, which is not a  
13 provision of Subchapter C, Chapter 531. The revised  
14 law substitutes "this chapter" for "this subchapter"  
15 and applies the definitions to the entire chapter,  
16 including the revised law derived from Section  
17 531.0215, because that section does not use any of the  
18 defined terms.

19 (2) The definitions of "inspector general" and  
20 "office of inspector general" are added to the revised  
21 law for drafting convenience and to eliminate  
22 frequent, unnecessary repetition of the substance of  
23 the definitions.

24 (3) Section 531.1011(10), Government Code,  
25 defines "provider" for purposes of Subchapter C,  
26 Chapter 531, Government Code, which is substantially  
27 revised in this chapter. Section 531.1031(a)(3),  
28 Government Code, which is revised in this chapter as  
29 Section 544.0151(5), defines "provider" in a different  
30 manner for purposes of Sections 531.1031, 531.1032,  
31 531.1033, and 531.1034, Government Code, each of which  
32 is included in Subchapter C, Chapter 531, and revised  
33 in Subchapter D of this chapter. For clarity and the  
34 convenience of the reader, the revised law in this  
35 section defines "provider" for purposes of the chapter  
36 in the manner specified by Section 531.1011(10),

1 "[e]xcept as otherwise provided by this chapter," to  
2 reflect that a different definition of the term  
3 applies in Subchapter D of this chapter.

4 (4) Section 531.1011(10), Government Code,  
5 refers to a person, "firm, partnership, corporation,  
6 agency, association, institution, or other entity."  
7 The revised law omits the quoted language because  
8 Section 311.005(2), Government Code (Code  
9 Construction Act), defines "person" to include any  
10 legal entity.

11 Revised Law

12 Sec. 544.0002. REFERENCE TO OFFICE OF INVESTIGATIONS AND  
13 ENFORCEMENT. Notwithstanding any other law, a reference in law or  
14 rule to the commission's office of investigations and enforcement  
15 means the office of inspector general. (Gov. Code, Sec.  
16 531.102(i).)

17 Source Law

18 (i) Notwithstanding any other provision of law,  
19 a reference in law or rule to the commission's office  
20 of investigations and enforcement means the office of  
21 inspector general established under this section.

22 Revisor's Note

23 Section 531.102(i), Government Code, refers to  
24 the office of inspector general "established under  
25 this section." The revised law omits the quoted  
26 language as unnecessary because Section 544.0001(7) of  
27 this chapter defines "office of inspector general" to  
28 mean the Health and Human Services Commission's office  
29 of inspector general.

30 Revised Law

31 Sec. 544.0003. AUTHORITY OF STATE AGENCY OR GOVERNMENTAL  
32 ENTITY NOT LIMITED. Nothing in the following provisions limits the  
33 authority of any other state agency or governmental entity:

34 (1) Section 544.0052;

35 (2) Section 544.0101;

- 1 (3) Section 544.0102;
- 2 (4) Section 544.0103;
- 3 (5) Section 544.0104;
- 4 (6) Section 544.0105;
- 5 (7) Section 544.0106;
- 6 (8) Section 544.0108;
- 7 (9) Sections 544.0109(b) and (d);
- 8 (10) Section 544.0110;
- 9 (11) Section 544.0113;
- 10 (12) Section 544.0114;
- 11 (13) Section 544.0251;
- 12 (14) Section 544.0252(b);
- 13 (15) Section 544.0254;
- 14 (16) Section 544.0255;
- 15 (17) Section 544.0257;
- 16 (18) Section 544.0301;
- 17 (19) Section 544.0302;
- 18 (20) Section 544.0303; and
- 19 (21) Section 544.0304. (Gov. Code, Sec. 531.102(o).)

20 Source Law

21 (o) Nothing in this section limits the authority  
22 of any other state agency or governmental entity.

23 Revisor's Note

24 Section 531.102(o), Government Code, states that  
25 nothing in Section 531.102 limits the authority of any  
26 other state agency or governmental entity. The  
27 relevant provisions of Section 531.102 that could be  
28 interpreted as limiting the authority of another state  
29 agency or governmental entity are revised in various  
30 provisions throughout this chapter, and the revised  
31 law references those relevant provisions.

1 SUBCHAPTER B. HEALTH AND HUMAN SERVICES COMMISSION: ADMINISTRATIVE  
2 PROVISIONS

3 Revised Law

4 Sec. 544.0051. COORDINATION WITH OFFICE OF ATTORNEY  
5 GENERAL; ANNUAL REPORT. (a) The commission, acting through the  
6 office of inspector general, and the office of the attorney general  
7 shall enter into a memorandum of understanding to develop and  
8 implement joint written procedures for processing:

9 (1) cases of suspected fraud, waste, or abuse, as  
10 those terms are defined by state or federal law; or

11 (2) other violations of state or federal law under  
12 Medicaid or another program the commission or a health and human  
13 services agency administers, including:

14 (A) the financial assistance program under  
15 Chapter 31, Human Resources Code;

16 (B) the supplemental nutrition assistance  
17 program under Chapter 33, Human Resources Code; and

18 (C) the child health plan program.

19 (b) The memorandum of understanding must:

20 (1) require the office of inspector general and the  
21 office of the attorney general to:

22 (A) set priorities and guidelines for referring  
23 cases to appropriate state agencies for investigation,  
24 prosecution, or other disposition to:

25 (i) enhance deterrence of fraud, waste,  
26 abuse, or other violations of state or federal law under the  
27 programs described by Subsection (a)(2), including a violation of  
28 Chapter 102, Occupations Code; and

29 (ii) maximize the imposition of penalties,  
30 the recovery of money, and the successful prosecution of cases; and

31 (B) submit information the comptroller requests  
32 about each resolved case for the comptroller's use in improving  
33 fraud detection;

34 (2) require the office of inspector general to:

1 (A) refer each case of suspected provider fraud,  
2 waste, or abuse to the office of the attorney general not later than  
3 the 20th business day after the date the office of inspector general  
4 determines that the existence of fraud, waste, or abuse is  
5 reasonably indicated;

6 (B) keep detailed records for cases the office of  
7 inspector general or the office of the attorney general processes,  
8 including information on the total number of cases processed and,  
9 for each case:

10 (i) the agency and division to which the  
11 case is referred for investigation;

12 (ii) the date the case is referred; and

13 (iii) the nature of the suspected fraud,  
14 waste, or abuse; and

15 (C) notify each appropriate division of the  
16 office of the attorney general of each case the office of inspector  
17 general refers;

18 (3) require the office of the attorney general to:

19 (A) take appropriate action in response to each  
20 case referred to the attorney general, which may include:

21 (i) directly initiating prosecution, with  
22 the appropriate local district or county attorney's consent;

23 (ii) directly initiating civil litigation;

24 (iii) referring the case to an appropriate  
25 United States attorney, a district attorney, or a county attorney;  
26 or

27 (iv) referring the case to a collections  
28 agency for initiation of civil litigation or other appropriate  
29 action;

30 (B) ensure that information relating to each case  
31 the office of the attorney general investigates is available to  
32 each division of the office with responsibility for investigating  
33 suspected fraud, waste, or abuse; and

34 (C) notify the office of inspector general of

1 each case the attorney general declines to prosecute or prosecutes  
2 unsuccessfully;

3 (4) require representatives of the office of inspector  
4 general and of the office of the attorney general to meet not less  
5 than quarterly to share case information and determine the  
6 appropriate agency and division to investigate each case;

7 (5) ensure that barriers to direct fraud referrals to  
8 the office of the attorney general's Medicaid fraud control unit or  
9 unreasonable impediments to communication between Medicaid agency  
10 employees and the Medicaid fraud control unit are not imposed; and

11 (6) include procedures to facilitate the referral of  
12 cases directly to the office of the attorney general.

13 (c) An exchange of information under this section between  
14 the office of the attorney general and the commission, the office of  
15 inspector general, or a health and human services agency does not  
16 affect whether the information is subject to disclosure under  
17 Chapter 552.

18 (d) The commission and the office of the attorney general  
19 may not assess or collect investigation and attorney's fees on any  
20 state agency's behalf unless the office of the attorney general or  
21 another state agency collects a penalty, restitution, or other  
22 reimbursement payment to this state.

23 (e) A district attorney, county attorney, city attorney, or  
24 private collection agency may collect and retain:

25 (1) costs associated with a case referred to the  
26 attorney or agency in accordance with procedures adopted under this  
27 section; and

28 (2) 20 percent of the amount of the penalty,  
29 restitution, or other reimbursement payment collected.

30 (f) The commission and the office of the attorney general  
31 shall jointly prepare and submit to the governor, lieutenant  
32 governor, and speaker of the house of representatives an annual  
33 report concerning the activities of those agencies in detecting and  
34 preventing fraud, waste, and abuse under Medicaid or another

1 program the commission or a health and human services agency  
2 administers. The commission and the office of the attorney general  
3 may consolidate the report with any other report relating to the  
4 same subject matter the commission or the office of the attorney  
5 general is required to submit under other law. (Gov. Code, Sec.  
6 531.103.)

7 Source Law

8 Sec. 531.103. INTERAGENCY COORDINATION. (a)  
9 The commission, acting through the commission's office  
10 of inspector general, and the office of the attorney  
11 general shall enter into a memorandum of understanding  
12 to develop and implement joint written procedures for  
13 processing cases of suspected fraud, waste, or abuse,  
14 as those terms are defined by state or federal law, or  
15 other violations of state or federal law under  
16 Medicaid or another program administered by the  
17 commission or a health and human services agency,  
18 including the financial assistance program under  
19 Chapter 31, Human Resources Code, the supplemental  
20 nutrition assistance program under Chapter 33, Human  
21 Resources Code, and the child health plan program. The  
22 memorandum of understanding shall require:

23 (1) the office of inspector general and  
24 the office of the attorney general to set priorities  
25 and guidelines for referring cases to appropriate  
26 state agencies for investigation, prosecution, or  
27 other disposition to enhance deterrence of fraud,  
28 waste, abuse, or other violations of state or federal  
29 law, including a violation of Chapter 102, Occupations  
30 Code, in the programs and maximize the imposition of  
31 penalties, the recovery of money, and the successful  
32 prosecution of cases;

33 (1-a) the office of inspector general to  
34 refer each case of suspected provider fraud, waste, or  
35 abuse to the office of the attorney general not later  
36 than the 20th business day after the date the office of  
37 inspector general determines that the existence of  
38 fraud, waste, or abuse is reasonably indicated;

39 (1-b) the office of the attorney general  
40 to take appropriate action in response to each case  
41 referred to the attorney general, which action may  
42 include direct initiation of prosecution, with the  
43 consent of the appropriate local district or county  
44 attorney, direct initiation of civil litigation,  
45 referral to an appropriate United States attorney, a  
46 district attorney, or a county attorney, or referral  
47 to a collections agency for initiation of civil  
48 litigation or other appropriate action;

49 (2) the office of inspector general to  
50 keep detailed records for cases processed by that  
51 office or the office of the attorney general,  
52 including information on the total number of cases  
53 processed and, for each case:

54 (A) the agency and division to which  
55 the case is referred for investigation;

56 (B) the date on which the case is  
57 referred; and

58 (C) the nature of the suspected  
59 fraud, waste, or abuse;

60 (3) the office of inspector general to

1 notify each appropriate division of the office of the  
2 attorney general of each case referred by the office of  
3 inspector general;

4 (4) the office of the attorney general to  
5 ensure that information relating to each case  
6 investigated by that office is available to each  
7 division of the office with responsibility for  
8 investigating suspected fraud, waste, or abuse;

9 (5) the office of the attorney general to  
10 notify the office of inspector general of each case the  
11 attorney general declines to prosecute or prosecutes  
12 unsuccessfully;

13 (6) representatives of the office of  
14 inspector general and of the office of the attorney  
15 general to meet not less than quarterly to share case  
16 information and determine the appropriate agency and  
17 division to investigate each case; and

18 (7) the office of inspector general and  
19 the office of the attorney general to submit  
20 information requested by the comptroller about each  
21 resolved case for the comptroller's use in improving  
22 fraud detection.

23 (b) An exchange of information under this  
24 section between the office of the attorney general and  
25 the commission, the office of inspector general, or a  
26 health and human services agency does not affect  
27 whether the information is subject to disclosure under  
28 Chapter 552.

29 (c) The commission and the office of the  
30 attorney general shall jointly prepare and submit an  
31 annual report to the governor, lieutenant governor,  
32 and speaker of the house of representatives concerning  
33 the activities of those agencies in detecting and  
34 preventing fraud, waste, and abuse under Medicaid or  
35 another program administered by the commission or a  
36 health and human services agency. The report may be  
37 consolidated with any other report relating to the  
38 same subject matter the commission or office of the  
39 attorney general is required to submit under other  
40 law.

41 (d) The commission and the office of the  
42 attorney general may not assess or collect  
43 investigation and attorney's fees on behalf of any  
44 state agency unless the office of the attorney general  
45 or other state agency collects a penalty, restitution,  
46 or other reimbursement payment to the state.

47 (e) In addition to the provisions required by  
48 Subsection (a), the memorandum of understanding  
49 required by this section must also ensure that no  
50 barriers to direct fraud referrals to the office of the  
51 attorney general's Medicaid fraud control unit or  
52 unreasonable impediments to communication between  
53 Medicaid agency employees and the Medicaid fraud  
54 control unit are imposed, and must include procedures  
55 to facilitate the referral of cases directly to the  
56 office of the attorney general.

57 (f) A district attorney, county attorney, city  
58 attorney, or private collection agency may collect and  
59 retain costs associated with a case referred to the  
60 attorney or agency in accordance with procedures  
61 adopted under this section and 20 percent of the amount  
62 of the penalty, restitution, or other reimbursement  
63 payment collected.

64 Revisor's Note

65 Section 531.103(a), Government Code, directs the

1 Health and Human Services Commission's office of  
2 inspector general and the office of the attorney  
3 general to enter into a memorandum of understanding  
4 that "shall" include certain requirements. The  
5 revised law substitutes "must" for "shall" because  
6 under Section 311.016, Government Code (Code  
7 Construction Act), applicable to this code, the term  
8 "shall" imposes a duty on an actor and the term "must"  
9 is more commonly used when no duty is imposed on an  
10 actor and the sentence's subject is an inanimate  
11 object.

12 Revised Law

13 Sec. 544.0052. RULES REGARDING ENFORCEMENT AND PUNITIVE  
14 ACTIONS. (a) The executive commissioner, in consultation with the  
15 office of inspector general, shall adopt rules establishing  
16 criteria for determining enforcement and punitive actions  
17 regarding a provider who violated state law, program rules, or the  
18 provider's Medicaid provider agreement.

19 (b) The rules must include:

20 (1) direction for categorizing provider violations  
21 according to the nature of the violation and for scaling resulting  
22 enforcement actions, taking into consideration:

23 (A) the seriousness of the violation;

24 (B) the prevalence of errors by the provider;

25 (C) the financial or other harm to this state or  
26 recipients resulting or potentially resulting from those errors;  
27 and

28 (D) mitigating factors the office of inspector  
29 general determines appropriate; and

30 (2) a specific list of potential penalties, including  
31 the amount of the penalties, for fraud and other Medicaid  
32 violations. (Gov. Code, Sec. 531.102(x).)

33 Source Law

34 (x) The executive commissioner, in consultation

1 with the office, shall adopt rules establishing  
2 criteria for determining enforcement and punitive  
3 actions with regard to a provider who has violated  
4 state law, program rules, or the provider's Medicaid  
5 provider agreement that include:

6 (1) direction for categorizing provider  
7 violations according to the nature of the violation  
8 and for scaling resulting enforcement actions, taking  
9 into consideration:

10 (A) the seriousness of the violation;  
11 (B) the prevalence of errors by the  
12 provider;

13 (C) the financial or other harm to  
14 the state or recipients resulting or potentially  
15 resulting from those errors; and

16 (D) mitigating factors the office  
17 determines appropriate; and

18 (2) a specific list of potential  
19 penalties, including the amount of the penalties, for  
20 fraud and other Medicaid violations.

21 Revised Law

22 Sec. 544.0053. PROVISION OF INFORMATION TO PHARMACY SUBJECT  
23 TO AUDIT; INFORMAL HEARING ON AUDIT FINDINGS. (a) To increase  
24 transparency, the office of inspector general shall, if the office  
25 has access to the information, provide to pharmacies that are  
26 subject to audit by the office or by an entity that contracts with  
27 the federal government to audit Medicaid providers information  
28 relating to the extrapolation methodology used as part of the audit  
29 and the methods used to determine whether the pharmacy has been  
30 overpaid under Medicaid in sufficient detail so that the audit  
31 results may be demonstrated to be statistically valid and are fully  
32 reproducible.

33 (b) A pharmacy has a right to request an informal hearing  
34 before the commission's appeals division to contest the findings of  
35 an audit that the office of inspector general or an entity that  
36 contracts with the federal government to audit Medicaid providers  
37 conducted if the audit findings do not include findings that the  
38 pharmacy engaged in Medicaid fraud.

39 (c) In an informal hearing held under this section, the  
40 commission's appeals division staff, assisted by staff responsible  
41 for the commission's vendor drug program with expertise in the law  
42 governing pharmacies' participation in Medicaid, make the final  
43 decision on whether the audit findings are accurate. Office of  
44 inspector general staff may not serve on the panel that makes the

1 decision on the accuracy of an audit. (Gov. Code, Sec. 531.1203.)

2 Source Law

3 Sec. 531.1203. RIGHTS OF AND PROVISION OF  
4 INFORMATION TO PHARMACIES SUBJECT TO CERTAIN AUDITS.

5 (a) A pharmacy has a right to request an informal  
6 hearing before the commission's appeals division to  
7 contest the findings of an audit conducted by the  
8 commission's office of inspector general or an entity  
9 that contracts with the federal government to audit  
10 Medicaid providers if the findings of the audit do not  
11 include findings that the pharmacy engaged in Medicaid  
12 fraud.

13 (b) In an informal hearing held under this  
14 section, staff of the commission's appeals division,  
15 assisted by staff responsible for the commission's  
16 vendor drug program who have expertise in the law  
17 governing pharmacies' participation in Medicaid, make  
18 the final decision on whether the findings of an audit  
19 are accurate. Staff of the commission's office of  
20 inspector general may not serve on the panel that makes  
21 the decision on the accuracy of an audit.

22 (c) In order to increase transparency, the  
23 commission's office of inspector general shall, if the  
24 office has access to the information, provide to  
25 pharmacies that are subject to audit by the office, or  
26 by an entity that contracts with the federal  
27 government to audit Medicaid providers, information  
28 relating to the extrapolation methodology used as part  
29 of the audit and the methods used to determine whether  
30 the pharmacy has been overpaid under Medicaid in  
31 sufficient detail so that the audit results may be  
32 demonstrated to be statistically valid and are fully  
33 reproducible.

34 Revised Law

35 Sec. 544.0054. RECORDS OF ALLEGATIONS OF FRAUD OR ABUSE.

36 The commission shall maintain a record of all allegations of fraud  
37 or abuse against a provider containing the date each allegation was  
38 received or identified and the source of the allegation, if  
39 available. The record is confidential under Section 544.0259(e)  
40 and is subject to Section 544.0259(f). (Gov. Code, Sec.  
41 531.118(a).)

42 Source Law

43 Sec. 531.118. PRELIMINARY INVESTIGATIONS OF  
44 ALLEGATIONS OF FRAUD OR ABUSE AND FRAUD REFERRALS. (a)  
45 The commission shall maintain a record of all  
46 allegations of fraud or abuse against a provider  
47 containing the date each allegation was received or  
48 identified and the source of the allegation, if  
49 available. The record is confidential under Section  
50 531.1021(g) and is subject to Section 531.1021(h).

51 Revised Law

52 Sec. 544.0055. RECORD AND CONFIDENTIALITY OF INFORMAL

1 RESOLUTION MEETINGS. (a) On the written request of a provider who  
2 requests an informal resolution meeting held under Section 544.0304  
3 or 544.0506(b), the commission shall, at no expense to the  
4 provider, provide for the meeting to be recorded and for the  
5 recording to be made available to the provider. The commission may  
6 not record an informal resolution meeting unless the commission  
7 receives a written request from a provider.

8 (b) Notwithstanding Section 544.0259(e) and except as  
9 provided by this section:

10 (1) an informal resolution meeting held under Section  
11 544.0304 or 544.0506(b) is confidential; and

12 (2) any information or materials the office of  
13 inspector general, including the office's employees or agents,  
14 obtains during or in connection with an informal resolution  
15 meeting, including a recording made under Subsection (a), are  
16 privileged, confidential, and not subject to disclosure under  
17 Chapter 552 or any other means of legal compulsion for release,  
18 including disclosure, discovery, or subpoena. (Gov. Code, Sec.  
19 531.1202.)

20 Source Law

21 Sec. 531.1202. RECORD AND CONFIDENTIALITY OF  
22 INFORMAL RESOLUTION MEETINGS. (a) On the written  
23 request of the provider, the commission shall, at no  
24 expense to the provider who requested the meeting,  
25 provide for an informal resolution meeting held under  
26 Section 531.102(g)(6) or 531.120(b) to be recorded.  
27 The recording of an informal resolution meeting shall  
28 be made available to the provider who requested the  
29 meeting. The commission may not record an informal  
30 resolution meeting unless the commission receives a  
31 written request from a provider under this subsection.

32 (b) Notwithstanding Section 531.1021(g) and  
33 except as provided by this section, an informal  
34 resolution meeting held under Section 531.102(g)(6) or  
35 531.120(b) is confidential, and any information or  
36 materials obtained by the commission's office of  
37 inspector general, including the office's employees or  
38 the office's agents, during or in connection with an  
39 informal resolution meeting, including a recording  
40 made under Subsection (a), are privileged and  
41 confidential and not subject to disclosure under  
42 Chapter 552 or any other means of legal compulsion for  
43 release, including disclosure, discovery, or  
44 subpoena.

1 Revised Law

2 Sec. 544.0056. EXPUNCTION OF CHILD'S CHEMICAL DEPENDENCY  
3 DIAGNOSIS IN CERTAIN RECORDS. (a) In this section:

4 (1) "Chemical dependency" has the meaning assigned by  
5 Section 461A.002, Health and Safety Code.

6 (2) "Child" means an individual who is 13 years of age  
7 or younger.

8 (b) After a chemical dependency treatment provider is  
9 finally convicted of an offense in which an element of the offense  
10 involves submitting a fraudulent claim for reimbursement for  
11 services under Medicaid, the commission or other health and human  
12 services agency that operates a portion of Medicaid shall expunge  
13 or provide for the expunction of a child's diagnosis of chemical  
14 dependency that the provider made and that has been entered in any:

15 (1) appropriate official record of the commission or  
16 agency;

17 (2) applicable medical record that is in the  
18 commission's or agency's custody; and

19 (3) applicable record of a company with which the  
20 commission contracts for processing and paying Medicaid claims.

21 (Gov. Code, Sec. 531.112.)

22 Source Law

23 Sec. 531.112. EXPUNCTION OF INFORMATION RELATED  
24 TO CERTAIN CHEMICAL DEPENDENCY DIAGNOSES IN CERTAIN  
25 RECORDS. (a) In this section:

26 (1) "Chemical dependency" has the meaning  
27 assigned by Section 461A.002, Health and Safety Code.

28 (2) "Child" means a person 13 years of age  
29 or younger.

30 (b) Following the final conviction of a chemical  
31 dependency treatment provider for an offense, an  
32 element of which involves submitting a fraudulent  
33 claim for reimbursement for services under Medicaid,  
34 the commission or other health and human services  
35 agency that operates a portion of Medicaid shall  
36 expunge or provide for the expunction of a diagnosis of  
37 chemical dependency in a child that has been made by  
38 the treatment provider and entered in any:

39 (1) appropriate official record of the  
40 commission or agency;

41 (2) applicable medical record that is in  
42 the commission's or agency's custody; and

43 (3) applicable record of a company that  
44 the commission contracts with for the processing and  
45 payment of claims under Medicaid.

1 Revisor's Note

2 Section 531.112(a)(2), Government Code, defines  
3 the term "child" to mean a "person" who is 13 years of  
4 age or younger. Throughout this chapter, the revised  
5 law substitutes "individual" for "person" for clarity  
6 and consistency where the context makes clear that the  
7 referenced person is an individual and not an entity  
8 described by the definition of "person" provided by  
9 Section 311.005(2), Government Code (Code  
10 Construction Act), applicable to this code.

11 SUBCHAPTER C. OFFICE OF INSPECTOR GENERAL: GENERAL PROVISIONS

12 Revised Law

13 Sec. 544.0101. APPOINTMENT OF INSPECTOR GENERAL; TERM. (a)  
14 The governor shall appoint an inspector general to serve as  
15 director of the office of inspector general.

16 (b) The inspector general serves a one-year term that  
17 expires February 1. (Gov. Code, Sec. 531.102(a-1).)

18 Source Law

19 (a-1) The governor shall appoint an inspector  
20 general to serve as director of the office. The  
21 inspector general serves a one-year term that expires  
22 on February 1.

23 Revised Law

24 Sec. 544.0102. COMMISSION POWERS AND DUTIES RELATED TO  
25 OFFICE OF INSPECTOR GENERAL. (a) The executive commissioner shall  
26 work in consultation with the office of inspector general when the  
27 executive commissioner is required by law to adopt a rule or policy  
28 necessary to implement a power or duty of the office, including a  
29 rule necessary to carry out a responsibility of the office under  
30 Section 544.0103(a).

31 (b) The executive commissioner is responsible for  
32 performing all administrative support services functions necessary  
33 to operate the office of inspector general in the same manner that  
34 the executive commissioner is responsible for providing  
35 administrative support services functions for the health and human

1 services system, including office functions related to:

2 (1) procurement processes;

3 (2) contracting policies;

4 (3) information technology services;

5 (4) legal services, but only those related to:

6 (A) open records;

7 (B) procurement;

8 (C) contracting;

9 (D) human resources;

10 (E) privacy;

11 (F) litigation support by the attorney general;

12 (G) bankruptcy; and

13 (H) other legal services as detailed in the

14 memorandum of understanding or other written agreement required

15 under Section \_\_\_\_\_ [[[Section 531.00553]]];

16 (5) budgeting; and

17 (6) personnel and employment policies.

18 (c) The commission's internal audit division shall:

19 (1) regularly audit the office of inspector general as  
20 part of the commission's internal audit program; and

21 (2) include the office in the commission's risk  
22 assessments.

23 (d) The commission's chief counsel is the final authority  
24 for all legal interpretations related to statutes, rules, and  
25 commission policies on programs the commission administers.

26 (e) The commission shall:

27 (1) in consultation with the inspector general, set  
28 clear objectives, priorities, and performance standards for the  
29 office of inspector general that emphasize:

30 (A) coordinating investigative efforts to  
31 aggressively recover money;

32 (B) allocating resources to cases that have the  
33 strongest supportive evidence and greatest potential to recover  
34 money; and

1 (C) maximizing opportunities for referral of  
2 cases to the office of the attorney general in accordance with  
3 Section 544.0051; and

4 (2) train office of inspector general staff to enable  
5 the staff to pursue priority Medicaid and other health and human  
6 services fraud and abuse cases as necessary.

7 (f) The commission may require employees of health and human  
8 services agencies to provide assistance to the office of inspector  
9 general in connection with the office's duties relating to the  
10 investigation of fraud and abuse in the provision of health and  
11 human services. The office is entitled to access to any information  
12 a health and human services agency maintains that is relevant to the  
13 office's functions, including internal records.

14 (g) To the extent permitted by federal law, the executive  
15 commissioner, on the office of inspector general's behalf, shall  
16 adopt rules establishing:

17 (1) criteria for:

18 (A) initiating a full-scale fraud or abuse  
19 investigation;

20 (B) conducting the investigation;

21 (C) collecting evidence; and

22 (D) accepting and approving a provider's request  
23 to post a surety bond to secure potential recoupments in lieu of a  
24 payment hold or other asset or payment guarantee; and

25 (2) minimum training requirements for Medicaid  
26 provider fraud or abuse investigators.

27 (h) The executive commissioner, in consultation with the  
28 office of inspector general, shall adopt rules establishing  
29 criteria:

30 (1) for opening a case;

31 (2) for prioritizing cases for the efficient  
32 management of the office's workload, including rules that direct  
33 the office to prioritize:

34 (A) provider cases according to the highest

1 potential for recovery or risk to this state as indicated through:

2 (i) the provider's volume of billings;

3 (ii) the provider's history of  
4 noncompliance with the law; and

5 (iii) identified fraud trends;

6 (B) recipient cases according to the highest  
7 potential for recovery and federal timeliness requirements; and

8 (C) internal affairs investigations according to  
9 the seriousness of the threat to recipient safety and the risk to  
10 program integrity in terms of the amount or scope of fraud, waste,  
11 and abuse the allegation that is the subject of the investigation  
12 poses; and

13 (3) to guide field investigators in closing a case  
14 that is not worth pursuing through a full investigation. (Gov.  
15 Code, Secs. 531.102(a-2), (a-3), (a-4), (a-7), (a-8), (b), (c),  
16 (d), (n), (p).)

17 Source Law

18 (a-2) The executive commissioner shall work in  
19 consultation with the office whenever the executive  
20 commissioner is required by law to adopt a rule or  
21 policy necessary to implement a power or duty of the  
22 office, including a rule necessary to carry out a  
23 responsibility of the office under Subsection (a).

24 (a-3) The executive commissioner is responsible  
25 for performing all administrative support services  
26 functions necessary to operate the office in the same  
27 manner that the executive commissioner is responsible  
28 for providing administrative support services  
29 functions for the health and human services system,  
30 including functions of the office related to the  
31 following:

- 32 (1) procurement processes;  
33 (2) contracting policies;  
34 (3) information technology services;  
35 (4) subject to Subsection (a-8), legal  
36 services;  
37 (5) budgeting; and  
38 (6) personnel and employment policies.

39 (a-4) The commission's internal audit division  
40 shall regularly audit the office as part of the  
41 commission's internal audit program and shall include  
42 the office in the commission's risk assessments.

43 (a-7) The chief counsel for the commission is  
44 the final authority for all legal interpretations  
45 related to statutes, rules, and commission policy on  
46 programs administered by the commission.

47 (a-8) For purposes of Subsection (a-3), "legal  
48 services" includes only legal services related to open  
49 records, procurement, contracting, human resources,

1 privacy, litigation support by the attorney general,  
2 bankruptcy, and other legal services as detailed in  
3 the memorandum of understanding or other written  
4 agreement required under Section 531.00553, as added  
5 by Chapter 837 (S.B. 200), Acts of the 84th  
6 Legislature, Regular Session, 2015.

7 (b) The commission, in consultation with the  
8 inspector general, shall set clear objectives,  
9 priorities, and performance standards for the office  
10 that emphasize:

11 (1) coordinating investigative efforts to  
12 aggressively recover money;

13 (2) allocating resources to cases that  
14 have the strongest supportive evidence and the  
15 greatest potential for recovery of money; and

16 (3) maximizing opportunities for referral  
17 of cases to the office of the attorney general in  
18 accordance with Section 531.103.

19 (c) The commission shall train office staff to  
20 enable the staff to pursue priority Medicaid and other  
21 health and human services fraud and abuse cases as  
22 necessary.

23 (d) The commission may require employees of  
24 health and human services agencies to provide  
25 assistance to the office in connection with the  
26 office's duties relating to the investigation of fraud  
27 and abuse in the provision of health and human  
28 services. The office is entitled to access to any  
29 information maintained by a health and human services  
30 agency, including internal records, relevant to the  
31 functions of the office.

32 (n) To the extent permitted under federal law,  
33 the executive commissioner, on behalf of the office,  
34 shall adopt rules establishing the criteria for  
35 initiating a full-scale fraud or abuse investigation,  
36 conducting the investigation, collecting evidence,  
37 accepting and approving a provider's request to post a  
38 surety bond to secure potential recoupments in lieu of  
39 a payment hold or other asset or payment guarantee, and  
40 establishing minimum training requirements for  
41 Medicaid provider fraud or abuse investigators.

42 (p) The executive commissioner, in consultation  
43 with the office, shall adopt rules establishing  
44 criteria:

45 (1) for opening a case;

46 (2) for prioritizing cases for the  
47 efficient management of the office's workload,  
48 including rules that direct the office to prioritize:

49 (A) provider cases according to the  
50 highest potential for recovery or risk to the state as  
51 indicated through the provider's volume of billings,  
52 the provider's history of noncompliance with the law,  
53 and identified fraud trends;

54 (B) recipient cases according to the  
55 highest potential for recovery and federal timeliness  
56 requirements; and

57 (C) internal affairs investigations  
58 according to the seriousness of the threat to  
59 recipient safety and the risk to program integrity in  
60 terms of the amount or scope of fraud, waste, and abuse  
61 posed by the allegation that is the subject of the  
62 investigation; and

63 (3) to guide field investigators in  
64 closing a case that is not worth pursuing through a  
65 full investigation.

1 Revised Law

2 Sec. 544.0103. OFFICE OF INSPECTOR GENERAL: GENERAL POWERS  
3 AND DUTIES. (a) The office of inspector general is responsible  
4 for:

5 (1) preventing, detecting, auditing, inspecting,  
6 reviewing, and investigating fraud, waste, and abuse in the  
7 provision and delivery of all health and human services in this  
8 state, including services provided:

9 (A) through any state-administered health or  
10 human services program that is wholly or partly federally funded;  
11 or

12 (B) by the Department of Family and Protective  
13 Services; and

14 (2) enforcing state law relating to providing those  
15 services.

16 (b) The commission may obtain any information or technology  
17 necessary for the office of inspector general to meet the office's  
18 responsibilities under this chapter or other law.

19 (c) The office of inspector general shall closely  
20 coordinate with the executive commissioner and relevant staff of  
21 health and human services system programs the office oversees in  
22 performing functions relating to preventing fraud, waste, and abuse  
23 in the delivery of health and human services and enforcing state law  
24 relating to the provision of those services, including audits,  
25 utilization reviews, provider education, and data analysis.

26 (d) The office of inspector general shall conduct audits,  
27 inspections, and investigations independent of the executive  
28 commissioner and the commission but shall rely on the coordination  
29 required by Subsection (c) to ensure that the office has a thorough  
30 understanding of the health and human services system to  
31 knowledgeably and effectively perform the office's duties.

32 (e) The office of inspector general may:

33 (1) assess administrative penalties otherwise  
34 authorized by law on behalf of the commission or a health and human

1 services agency;

2 (2) request that the attorney general obtain an  
3 injunction to prevent a person from disposing of an asset the office  
4 identifies as potentially subject to recovery by the office due to  
5 the person's fraud or abuse;

6 (3) provide for coordination between the office and  
7 special investigative units formed by managed care organizations  
8 under Subchapter H or entities with which managed care  
9 organizations contract under that subchapter;

10 (4) audit the use and effectiveness of state or  
11 federal money, including contract and grant money, administered by  
12 a person or state agency receiving the money from a health and human  
13 services agency;

14 (5) conduct investigations relating to the money  
15 described by Subdivision (4); and

16 (6) recommend policies to:

17 (A) promote the economical and efficient  
18 administration of the money described by Subdivision (4); and

19 (B) prevent and detect fraud and abuse in the  
20 administration of that money. (Gov. Code, Secs. 531.102(a), (a-5),  
21 (a-6), (h).)

22 Source Law

23 Sec. 531.102. OFFICE OF INSPECTOR GENERAL. (a)  
24 The commission's office of inspector general is  
25 responsible for the prevention, detection, audit,  
26 inspection, review, and investigation of fraud, waste,  
27 and abuse in the provision and delivery of all health  
28 and human services in the state, including services  
29 through any state-administered health or human  
30 services program that is wholly or partly federally  
31 funded or services provided by the Department of  
32 Family and Protective Services, and the enforcement of  
33 state law relating to the provision of those services.  
34 The commission may obtain any information or  
35 technology necessary to enable the office to meet its  
36 responsibilities under this subchapter or other law.

37 (a-5) The office shall closely coordinate with  
38 the executive commissioner and the relevant staff of  
39 health and human services system programs that the  
40 office oversees in performing functions relating to  
41 the prevention of fraud, waste, and abuse in the  
42 delivery of health and human services and the  
43 enforcement of state law relating to the provision of  
44 those services, including audits, utilization

1 reviews, provider education, and data analysis.

2 (a-6) The office shall conduct audits,  
3 inspections, and investigations independent of the  
4 executive commissioner and the commission but shall  
5 rely on the coordination required by Subsection (a-5)  
6 to ensure that the office has a thorough understanding  
7 of the health and human services system for purposes of  
8 knowledgeably and effectively performing the office's  
9 duties under this section and any other law.

10 (h) In addition to performing functions and  
11 duties otherwise provided by law, the office may:

12 (1) assess administrative penalties  
13 otherwise authorized by law on behalf of the  
14 commission or a health and human services agency;

15 (2) request that the attorney general  
16 obtain an injunction to prevent a person from  
17 disposing of an asset identified by the office as  
18 potentially subject to recovery by the office due to  
19 the person's fraud or abuse;

20 (3) provide for coordination between the  
21 office and special investigative units formed by  
22 managed care organizations under Section 531.113 or  
23 entities with which managed care organizations  
24 contract under that section;

25 (4) audit the use and effectiveness of  
26 state or federal funds, including contract and grant  
27 funds, administered by a person or state agency  
28 receiving the funds from a health and human services  
29 agency;

30 (5) conduct investigations relating to the  
31 funds described by Subdivision (4); and

32 (6) recommend policies promoting  
33 economical and efficient administration of the funds  
34 described by Subdivision (4) and the prevention and  
35 detection of fraud and abuse in administration of  
36 those funds.

37 Revisor's Note

38 (1) Section 531.102(a), Government Code, refers  
39 to the responsibilities of the Health and Human  
40 Services Commission's office of inspector general  
41 under "this subchapter," meaning Subchapter C, Chapter  
42 531, Government Code, "or other law," and Section  
43 531.102(a-6), Government Code, refers to the office's  
44 duties under "this section," meaning Section 531.102,  
45 Government Code, "and any other law." The provisions  
46 of the referenced subchapter and section relating to  
47 the responsibilities and duties of the office are  
48 revised throughout this chapter. The revised law  
49 substitutes "this chapter" for the references to "this  
50 subchapter" and "this section" because each provision  
51 revised in this chapter that is not derived from the

1 referenced source law is already included in the  
2 source law reference to "other law."

3 (2) Section 531.102(h), Government Code,  
4 permits the Health and Human Services Commission's  
5 office of inspector general to engage in certain  
6 actions "[i]n addition to performing functions and  
7 duties otherwise provided by law." The revised law  
8 omits the quoted language as redundant because the  
9 authorizations provided by other law to perform those  
10 functions and duties apply by their own terms, and an  
11 additional statement to that effect is unnecessary.

12 (3) Sections 531.102(h)(4), (5), and (6),  
13 Government Code, refer to state or federal "funds,"  
14 including contract and grant "funds." Throughout this  
15 chapter, the revised law substitutes "money" for  
16 "funds" because, in context, the meaning is the same  
17 and "money" is the more commonly used term.

18 Revised Law

19 Sec. 544.0104. EMPLOYMENT OF MEDICAL DIRECTOR. (a) The  
20 office of inspector general shall employ a medical director who:

21 (1) is a licensed physician under Subtitle B, Title 3,  
22 Occupations Code, and the rules the Texas Medical Board adopts  
23 under that subtitle; and

24 (2) preferably has significant knowledge of Medicaid.

25 (b) The medical director shall ensure that any  
26 investigative findings based on medical necessity or the quality of  
27 medical care have been reviewed by a qualified expert as described  
28 by the Texas Rules of Evidence before the office of inspector  
29 general imposes a payment hold or seeks recoupment of an  
30 overpayment, damages, or penalties. (Gov. Code, Sec. 531.102(1).)

31 Source Law

32 (1) The office shall employ a medical director  
33 who is a licensed physician under Subtitle B, Title 3,  
34 Occupations Code, and the rules adopted under that  
35 subtitle by the Texas Medical Board, and who  
36 preferably has significant knowledge of

1 Medicaid. The medical director shall ensure that any  
2 investigative findings based on medical necessity or  
3 the quality of medical care have been reviewed by a  
4 qualified expert as described by the Texas Rules of  
5 Evidence before the office imposes a payment hold or  
6 seeks recoupment of an overpayment, damages, or  
7 penalties.

8 Revised Law

9 Sec. 544.0105. EMPLOYMENT OF DENTAL DIRECTOR. (a) The  
10 office of inspector general shall employ a dental director who:

11 (1) is a licensed dentist under Subtitle D, Title 3,  
12 Occupations Code, and the rules the State Board of Dental Examiners  
13 adopts under that subtitle; and

14 (2) preferably has significant knowledge of Medicaid.

15 (b) The dental director shall ensure that any investigative  
16 findings based on the necessity of dental services or the quality of  
17 dental care have been reviewed by a qualified expert as described by  
18 the Texas Rules of Evidence before the office of inspector general  
19 imposes a payment hold or seeks recoupment of an overpayment,  
20 damages, or penalties. (Gov. Code, Sec. 531.102(m).)

21 Source Law

22 (m) The office shall employ a dental director  
23 who is a licensed dentist under Subtitle D, Title 3,  
24 Occupations Code, and the rules adopted under that  
25 subtitle by the State Board of Dental Examiners, and  
26 who preferably has significant knowledge of  
27 Medicaid. The dental director shall ensure that any  
28 investigative findings based on the necessity of  
29 dental services or the quality of dental care have been  
30 reviewed by a qualified expert as described by the  
31 Texas Rules of Evidence before the office imposes a  
32 payment hold or seeks recoupment of an overpayment,  
33 damages, or penalties.

34 Revised Law

35 Sec. 544.0106. CONTRACT FOR REVIEW OF INVESTIGATIVE  
36 FINDINGS BY QUALIFIED EXPERT. (a) If the commission does not  
37 receive any responsive bids under Chapter 2155 on a competitive  
38 solicitation for the services of a qualified expert to review  
39 investigative findings under Section 544.0104 or 544.0105 and the  
40 number of contracts to be awarded under this subsection is not  
41 otherwise limited, the commission may negotiate with and award a  
42 contract for the services to a qualified expert on the basis of:

43 (1) the contractor's agreement to a set fee, either as

1 a range or lump-sum amount; and

2 (2) the contractor's affirmation and the office of  
3 inspector general's verification that the contractor possesses the  
4 necessary occupational licenses and experience.

5 (b) Notwithstanding Sections 2155.083 and 2261.051, a  
6 contract awarded under Subsection (a) is not subject to competitive  
7 advertising and proposal evaluation requirements. (Gov. Code,  
8 Secs. 531.102(m-1), (m-2).)

9 Source Law

10 (m-1) If the commission does not receive any  
11 responsive bids under Chapter 2155 on a competitive  
12 solicitation for the services of a qualified expert to  
13 review investigative findings under Subsection (l) or  
14 (m) and the number of contracts to be awarded under  
15 this subsection is not otherwise limited, the  
16 commission may negotiate with and award a contract for  
17 the services to a qualified expert on the basis of:

18 (1) the contractor's agreement to a set  
19 fee, either as a range or lump-sum amount; and

20 (2) the contractor's affirmation and the  
21 office's verification that the contractor possesses  
22 the necessary occupational licenses and experience.

23 (m-2) Notwithstanding Sections 2155.083 and  
24 2261.051, a contract awarded under Subsection (m-1) is  
25 not subject to competitive advertising and proposal  
26 evaluation requirements.

27 Revised Law

28 Sec. 544.0107. EMPLOYMENT OF PEACE OFFICERS. (a) The  
29 office of inspector general shall employ and commission not more  
30 than five peace officers at any given time to assist the office in  
31 carrying out the office's duties relating to the investigation of  
32 Medicaid fraud, waste, and abuse.

33 (b) A peace officer the office of inspector general employs  
34 and commissions is administratively attached to the Department of  
35 Public Safety. The commission shall provide administrative support  
36 to the department as necessary to support the assignment of the  
37 peace officers.

38 (c) A peace officer the office of inspector general employs  
39 and commissions:

40 (1) is a peace officer for purposes of Article 2.12,  
41 Code of Criminal Procedure; and

42 (2) shall obtain the office of the attorney general's

1 prior approval before carrying out any duties requiring peace  
2 officer status. (Gov. Code, Sec. 531.1022.)

3 Source Law

4 Sec. 531.1022. PEACE OFFICERS. (a) The  
5 commission's office of inspector general shall employ  
6 and commission not more than five peace officers at any  
7 given time for the purpose of assisting the office in  
8 carrying out the duties of the office relating to the  
9 investigation of fraud, waste, and abuse in Medicaid.

10 (b) Peace officers employed under this section  
11 are administratively attached to the Department of  
12 Public Safety. The commission shall provide  
13 administrative support to the department necessary to  
14 support the assignment of peace officers employed  
15 under this section.

16 (c) A peace officer employed and commissioned by  
17 the office under this section is a peace officer for  
18 purposes of Article 2.12, Code of Criminal Procedure.

19 (d) A peace officer employed and commissioned  
20 under this section shall obtain prior approval from  
21 the office of attorney general before carrying out any  
22 duties requiring peace officer status.

23 Revised Law

24 Sec. 544.0108. INVESTIGATIVE PROCESS REVIEW. (a) Office  
25 of inspector general staff who are not directly involved in  
26 investigations the office conducts shall review the office's  
27 investigative process, including the office's use of sampling and  
28 extrapolation to audit provider records.

29 (b) The office of inspector general shall arrange for the  
30 Association of Inspectors General or a similar third party to  
31 conduct a peer review of the office's sampling and extrapolation  
32 techniques. Based on the review and generally accepted practices  
33 among other offices of inspectors general, the executive  
34 commissioner, in consultation with the office, shall by rule adopt  
35 sampling and extrapolation standards for the office's use in  
36 conducting audits. (Gov. Code, Secs. 531.102(r), (s).)

37 Source Law

38 (r) The office shall review the office's  
39 investigative process, including the office's use of  
40 sampling and extrapolation to audit provider records.  
41 The review shall be performed by staff who are not  
42 directly involved in investigations conducted by the  
43 office.

44 (s) The office shall arrange for the Association  
45 of Inspectors General or a similar third party to  
46 conduct a peer review of the office's sampling and  
47 extrapolation techniques. Based on the review and  
48 generally accepted practices among other offices of

1 inspectors general, the executive commissioner, in  
2 consultation with the office, shall by rule adopt  
3 sampling and extrapolation standards to be used by the  
4 office in conducting audits.

5 Revised Law

6 Sec. 544.0109. PERFORMANCE AUDITS AND COORDINATION OF AUDIT  
7 ACTIVITIES. (a) Notwithstanding any other law, the office of  
8 inspector general may conduct a performance audit of any program or  
9 project administered or agreement entered into by the commission or  
10 a health and human services agency, including an audit related to:

11 (1) the commission's or a health and human services  
12 agency's contracting procedures; or

13 (2) the commission's or a health and human services  
14 agency's performance.

15 (b) The office of inspector general shall coordinate all  
16 audit and oversight activities, including those relating to  
17 providers and including developing audit plans, risk assessments,  
18 and findings, with the commission to minimize duplicative  
19 activities. In coordinating the activities, the office shall:

20 (1) to determine whether to audit a Medicaid managed  
21 care organization, annually seek the commission's input and  
22 consider previous audits and on-site visits the commission made;  
23 and

24 (2) request the results of an informal audit or  
25 on-site visit the commission performed that could inform the  
26 office's risk assessment when determining whether to conduct or the  
27 scope of an audit of a Medicaid managed care organization.

28 (c) In addition to the coordination required by Subsection  
29 (b), the office of inspector general shall coordinate the office's  
30 other audit activities with those of the commission, including  
31 developing audit plans, performing risk assessments, and reporting  
32 findings, to minimize duplicative audit activities. In  
33 coordinating audit activities with the commission under this  
34 subsection, the office shall:

35 (1) to determine whether to conduct a performance  
36 audit, seek the commission's input and consider previous audits the

1 commission conducted; and

2 (2) request the results of an audit the commission  
3 conducted if those results could inform the office's risk  
4 assessment when determining whether to conduct or the scope of a  
5 performance audit.

6 (d) In accordance with Section \_\_\_\_ [[[Section  
7 533.015(b)]]], the office of inspector general shall consult with  
8 the executive commissioner regarding the adoption of rules defining  
9 the office's role in and jurisdiction over, and the frequency of,  
10 audits of Medicaid managed care organizations that the office and  
11 commission conduct. (Gov. Code, Secs. 531.102(q), (v), (w),  
12 531.1025.)

13 Source Law

14 [Sec. 531.102]

15 (q) The office shall coordinate all audit and  
16 oversight activities, including the development of  
17 audit plans, risk assessments, and findings, with the  
18 commission to minimize the duplication of activities.  
19 In coordinating activities under this subsection, the  
20 office shall:

21 (1) on an annual basis, seek input from the  
22 commission and consider previous audits and onsite  
23 visits made by the commission for purposes of  
24 determining whether to audit a managed care  
25 organization participating in Medicaid; and

26 (2) request the results of any informal  
27 audit or onsite visit performed by the commission that  
28 could inform the office's risk assessment when  
29 determining whether to conduct, or the scope of, an  
30 audit of a managed care organization participating in  
31 Medicaid.

32 (v) In accordance with Section 533.015(b), the  
33 office shall consult with the executive commissioner  
34 regarding the adoption of rules defining the office's  
35 role in and jurisdiction over, and the frequency of,  
36 audits of managed care organizations participating in  
37 Medicaid that are conducted by the office and the  
38 commission.

39 (w) The office shall coordinate all audit and  
40 oversight activities relating to providers, including  
41 the development of audit plans, risk assessments, and  
42 findings, with the commission to minimize the  
43 duplication of activities. In coordinating activities  
44 under this subsection, the office shall:

45 (1) on an annual basis, seek input from the  
46 commission and consider previous audits and on-site  
47 visits made by the commission for purposes of  
48 determining whether to audit a managed care  
49 organization participating in Medicaid; and

50 (2) request the results of any informal  
51 audit or on-site visit performed by the commission  
52 that could inform the office's risk assessment when  
53 determining whether to conduct, or the scope of, an

1 audit of a managed care organization participating in  
2 Medicaid.

3 Sec. 531.1025. PERFORMANCE AUDITS AND  
4 COORDINATION OF AUDIT ACTIVITIES. (a)  
5 Notwithstanding any other law, the commission's office  
6 of inspector general may conduct a performance audit  
7 of any program or project administered or agreement  
8 entered into by the commission or a health and human  
9 services agency, including an audit related to:

10 (1) contracting procedures of the  
11 commission or a health and human services agency; or

12 (2) the performance of the commission or a  
13 health and human services agency.

14 (b) In addition to the coordination required by  
15 Section 531.102(w), the office shall coordinate the  
16 office's other audit activities with those of the  
17 commission, including the development of audit plans,  
18 the performance of risk assessments, and the reporting  
19 of findings, to minimize the duplication of audit  
20 activities. In coordinating audit activities with the  
21 commission under this subsection, the office shall:

22 (1) seek input from the commission and  
23 consider previous audits conducted by the commission  
24 for purposes of determining whether to conduct a  
25 performance audit; and

26 (2) request the results of an audit  
27 conducted by the commission if those results could  
28 inform the office's risk assessment when determining  
29 whether to conduct, or the scope of, a performance  
30 audit.

31 Revisor's Note

32 Sections 531.102(q), (v), and (w), Government  
33 Code, refer to managed care organizations  
34 participating in Medicaid. A managed care  
35 organization that participates in Medicaid is a  
36 Medicaid managed care organization, which is defined  
37 by Section \_\_\_\_\_ [[[Section 531.001]]] as a managed  
38 care organization that contracts with the Health and  
39 Human Services Commission under Chapter 533,  
40 Government Code, which is revised in this subtitle as  
41 Chapter \_\_, to provide health care services to  
42 Medicaid recipients. That definition applies  
43 subtitle-wide, including to the law revised in this  
44 chapter. For consistency of terminology, the revised  
45 law substitutes references to a "Medicaid managed care  
46 organization" for references to a "managed care  
47 organization participating in Medicaid."

1 Revised Law

2 Sec. 544.0110. REPORTS ON AUDITS, INSPECTIONS, AND  
3 INVESTIGATIONS. (a) The office of inspector general shall prepare  
4 a final report on each audit, inspection, or investigation  
5 conducted under Section 544.0102, 544.0103, 544.0252(b), 544.0254,  
6 or 544.0257. The final report must include:

7 (1) a summary of the activities the office performed  
8 in conducting the audit, inspection, or investigation;

9 (2) a statement on whether the audit, inspection, or  
10 investigation resulted in a finding of any wrongdoing; and

11 (3) a description of any findings of wrongdoing.

12 (b) A final report on an audit, inspection, or investigation  
13 is subject to required disclosure under Chapter 552. All  
14 information and materials compiled during the audit, inspection, or  
15 investigation remain confidential and not subject to required  
16 disclosure in accordance with Section 544.0259(e).

17 (c) A confidential draft report on an audit, inspection, or  
18 investigation that concerns the death of a child may be shared with  
19 the Department of Family and Protective Services. A draft report  
20 that is shared with the Department of Family and Protective  
21 Services remains confidential and is not subject to disclosure  
22 under Chapter 552. (Gov. Code, Secs. 531.102(j), (k).)

23 Source Law

24 (j) The office shall prepare a final report on  
25 each audit, inspection, or investigation conducted  
26 under this section. The final report must include:

27 (1) a summary of the activities performed  
28 by the office in conducting the audit, inspection, or  
29 investigation;

30 (2) a statement regarding whether the  
31 audit, inspection, or investigation resulted in a  
32 finding of any wrongdoing; and

33 (3) a description of any findings of  
34 wrongdoing.

35 (k) A final report on an audit, inspection, or  
36 investigation is subject to required disclosure under  
37 Chapter 552. All information and materials compiled  
38 during the audit, inspection, or investigation remain  
39 confidential and not subject to required disclosure in  
40 accordance with Section 531.1021(g). A confidential  
41 draft report on an audit, inspection, or investigation  
42 that concerns the death of a child may be shared with  
43 the Department of Family and Protective Services. A  
44 draft report that is shared with the Department of

1 Family and Protective Services remains confidential  
2 and is not subject to disclosure under Chapter 552.

3 Revisor's Note

4 Section 531.102(j), Government Code, refers to a  
5 final report on each audit, inspection, or  
6 investigation conducted under "this section," meaning  
7 Section 531.102, Government Code. The provisions of  
8 Section 531.102 that relate to the conduct of an audit,  
9 inspection, or investigation are revised in various  
10 provisions throughout this chapter, and the revised  
11 law references the relevant provisions.

12 Revised Law

13 Sec. 544.0111. COMPLIANCE WITH FEDERAL CODING GUIDELINES.

14 (a) In this section, "federal coding guidelines" means the code  
15 sets and guidelines the United States Department of Health and  
16 Human Services adopts in accordance with the Health Insurance  
17 Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d  
18 et seq.).

19 (b) The office of inspector general, including office staff  
20 and any third party with which the office contracts to perform  
21 coding services, and the commission's medical and utilization  
22 review appeals unit shall comply with federal coding guidelines,  
23 including guidelines for diagnosis-related group (DRG) validation  
24 and related audits. (Gov. Code, Sec. 531.1023.)

25 Source Law

26 Sec. 531.1023. COMPLIANCE WITH FEDERAL CODING  
27 GUIDELINES. (a) The commission's office of inspector  
28 general, including office staff and any third party  
29 with which the office contracts to perform coding  
30 services, and the commission's medical and utilization  
31 review appeals unit shall comply with federal coding  
32 guidelines, including guidelines for  
33 diagnosis-related group (DRG) validation and related  
34 audits.

35 (b) In this section, "federal coding  
36 guidelines" means the code sets and guidelines adopted  
37 by the United States Department of Health and Human  
38 Services in accordance with the Health Insurance  
39 Portability and Accountability Act of 1996 (42 U.S.C.  
40 Section 1320d et seq.).

41 Revised Law

42 Sec. 544.0112. HOSPITAL UTILIZATION REVIEWS AND AUDITS:

1 PROVIDER EDUCATION PROCESS. The executive commissioner, in  
2 consultation with the office of inspector general, shall develop by  
3 rule a process for the office, including office staff and any third  
4 party with which the office contracts to perform coding services,  
5 to communicate with and educate providers about the  
6 diagnosis-related group (DRG) validation criteria that the office  
7 uses in conducting hospital utilization reviews and audits. (Gov.  
8 Code, Sec. 531.1024.)

9 Source Law

10 Sec. 531.1024. HOSPITAL UTILIZATION REVIEWS AND  
11 AUDITS: PROVIDER EDUCATION PROCESS. The executive  
12 commissioner, in consultation with the office, shall  
13 by rule develop a process for the commission's office  
14 of inspector general, including office staff and any  
15 third party with which the office contracts to perform  
16 coding services, to communicate with and educate  
17 providers about the diagnosis-related group (DRG)  
18 validation criteria that the office uses in conducting  
19 hospital utilization reviews and audits.

20 Revised Law

21 Sec. 544.0113. PROGRAM EXCLUSIONS. The office of inspector  
22 general, in consultation with this state's Medicaid fraud control  
23 unit, shall establish guidelines under which program exclusions:

- 24 (1) may permissively be imposed on a provider; or  
25 (2) shall automatically be imposed on a provider.  
26 (Gov. Code, Sec. 531.102(g)(7).)

27 Source Law

28 (7) The office shall, in consultation with  
29 the state's Medicaid fraud control unit, establish  
30 guidelines under which program exclusions:  
31 (A) may permissively be imposed on a  
32 provider; or  
33 (B) shall automatically be imposed on  
34 a provider.

35 Revised Law

36 Sec. 544.0114. REPORT. (a) At each quarterly meeting of  
37 any advisory council responsible for advising the executive  
38 commissioner on the commission's operation, the inspector general  
39 shall submit to the executive commissioner, the governor, and the  
40 legislature a report on:

- 41 (1) the office of inspector general's activities;

1 (2) the office's performance with respect to  
2 performance measures the executive commissioner establishes for  
3 the office;

4 (3) fraud trends the office has identified;

5 (4) any recommendations for policy changes to prevent  
6 or address fraud, waste, and abuse in the delivery of health and  
7 human services in this state; and

8 (5) the amount of money recovered during the preceding  
9 quarter as a result of investigations involving peace officers  
10 employed and commissioned by the office for each program for which  
11 the office has investigative authority.

12 (b) The office of inspector general shall publish each  
13 report required under this section on the office's Internet  
14 website. (Gov. Code, Secs. 531.102(t), (u).)

15 Source Law

16 (t) At each quarterly meeting of any advisory  
17 council responsible for advising the executive  
18 commissioner on the operation of the commission, the  
19 inspector general shall submit a report to the  
20 executive commissioner, the governor, and the  
21 legislature on:

22 (1) the office's activities;

23 (2) the office's performance with respect  
24 to performance measures established by the executive  
25 commissioner for the office;

26 (3) fraud trends identified by the office;

27 (4) any recommendations for changes in  
28 policy to prevent or address fraud, waste, and abuse in  
29 the delivery of health and human services in this  
30 state; and

31 (5) the amount of money recovered during  
32 the preceding quarter as a result of investigations  
33 involving peace officers employed and commissioned by  
34 the office for each program for which the office has  
35 investigative authority.

36 (u) The office shall publish each report  
37 required under Subsection (t) on the office's Internet  
38 website.

39 SUBCHAPTER D. MEDICAID PROVIDER CRIMINAL HISTORY RECORD

40 INFORMATION AND ELIGIBILITY

41 Revised Law

42 Sec. 544.0151. DEFINITIONS. In this subchapter:

43 (1) "Health care professional" means an individual  
44 issued a license to engage in a health care profession.

45 (2) "License" means a license, certificate,

1 registration, permit, or other authorization that:

2 (A) a licensing authority issues; and

3 (B) must be obtained before a person may practice  
4 or engage in a particular business, occupation, or profession.

5 (3) "Licensing authority" means a department,  
6 commission, board, office, or other state agency that issues a  
7 license.

8 (4) "Participating agency" means:

9 (A) the Medicaid fraud enforcement divisions of  
10 the office of the attorney general;

11 (B) each licensing authority with authority to  
12 issue a license to a health care professional or managed care  
13 organization that may participate in Medicaid; and

14 (C) the office of inspector general.

15 (5) "Provider" means a person that was or is approved  
16 by the commission to provide Medicaid services under a contract or  
17 provider agreement with the commission. (Gov. Code, Secs.  
18 531.1011(10) (part), 531.1031(a)(1), (1-a), (1-b), (2), (3).)

19 Source Law

20 [Sec. 531.1011.]

21 (10) "Provider" means a person, firm,  
22 partnership, corporation, agency, association,  
23 institution, or other entity that was or is approved by  
24 the commission to:

25 (A) provide Medicaid services under a  
26 contract or provider agreement with the commission; or  
27 . . . .

28 Sec. 531.1031. DUTY TO EXCHANGE INFORMATION.  
29 (a) In this section and Sections 531.1032, 531.1033,  
30 and 531.1034:

31 (1) "Health care professional" means a  
32 person issued a license to engage in a health care  
33 profession.

34 (1-a) "License" means a license,  
35 certificate, registration, permit, or other  
36 authorization that:

37 (A) is issued by a licensing  
38 authority; and

39 (B) must be obtained before a person  
40 may practice or engage in a particular business,  
41 occupation, or profession.

42 (1-b) "Licensing authority" means a  
43 department, commission, board, office, or other agency  
44 of the state that issues a license.

45 (2) "Participating agency" means:

46 (A) the Medicaid fraud enforcement

1 divisions of the office of the attorney general;  
2 (B) each licensing authority with  
3 authority to issue a license to a health care  
4 professional or managed care organization that may  
5 participate in Medicaid; and  
6 (C) the office.  
7 (3) "Provider" has the meaning assigned by  
8 Section 531.1011(10)(A).

9 Revisor's Note

10 Section 531.1031(a)(1-c), Government Code,  
11 defines "office" for purposes of Sections 531.1031,  
12 531.1032, 531.1033, and 531.1034, Government Code,  
13 which are revised as this subchapter, as the Health and  
14 Human Services Commission's office of inspector  
15 general "unless a different meaning is plainly  
16 required by the context in which the term appears."  
17 Section 544.0001(7) of this chapter defines "office of  
18 inspector general" for purposes of this chapter to  
19 mean the commission's office of inspector general. The  
20 revised law omits the definition of "office" provided  
21 by Section 531.1031(a)(1-c) as unnecessary because of  
22 the chapter-wide definition provided by Section  
23 544.0001(7), and to the extent a different meaning is  
24 required by the context, the revised law throughout  
25 this subchapter clarifies that different meaning. The  
26 omitted law reads:

27 (1-c) "Office" means the commission's  
28 office of inspector general unless a  
29 different meaning is plainly required by  
30 the context in which the term appears.

31 Revised Law

32 Sec. 544.0152. EXCHANGE OF CRIMINAL HISTORY RECORD  
33 INFORMATION BETWEEN PARTICIPATING AGENCIES. (a) This section  
34 applies only to:

35 (1) criminal history record information a  
36 participating agency holds that relates to a health care  
37 professional; and

38 (2) information a participating agency holds that  
39 relates to a health care professional or managed care organization

1 that is the subject of an investigation by a participating agency  
2 for alleged Medicaid fraud or abuse.

3 (b) A participating agency may submit to another  
4 participating agency a written request for information to which  
5 this section applies. The participating agency that receives the  
6 request shall provide the requesting agency with the requested  
7 information unless releasing the information:

8 (1) would jeopardize an ongoing investigation or  
9 prosecution by the participating agency that possesses the  
10 information; or

11 (2) is prohibited by other law.

12 (c) Notwithstanding any other law, a participating agency  
13 may enter into a memorandum of understanding or agreement with  
14 another participating agency for exchanging criminal history  
15 record information relating to a health care professional that both  
16 participating agencies are authorized access to under Chapter 411.  
17 Confidential criminal history record information in a  
18 participating agency's possession that is provided to another  
19 participating agency remains confidential while in the possession  
20 of the participating agency that receives the information.

21 (d) A participating agency that discovers information that  
22 may indicate fraud or abuse by a health care professional or managed  
23 care organization may provide the information to any other  
24 participating agency unless the release of the information is  
25 prohibited by other law.

26 (e) If after receiving a request for information under  
27 Subsection (b) a participating agency determines that the agency is  
28 prohibited from releasing the information, the agency shall, not  
29 later than the 30th day after the date the agency received the  
30 request, inform the requesting agency of that determination in  
31 writing.

32 (f) Confidential information shared under this section is  
33 subject to the same confidentiality requirements and legal  
34 restrictions on access to the information that are imposed by law on

1 the participating agency that originally obtained or collected the  
2 information. Sharing information under this section does not  
3 affect whether the information is subject to disclosure under  
4 Chapter 552.

5 (g) A participating agency that receives information from  
6 another participating agency under this section must obtain written  
7 permission from the agency that shared the information before using  
8 the information in a licensure or enforcement action.

9 (h) This section does not affect a participating agency's  
10 authority to exchange information under other law. (Gov. Code,  
11 Secs. 531.1031(b), (c), (c-1), (d), (e), (f), (g), (h).)

12 Source Law

13 (b) This section applies only to criminal  
14 history record information held by a participating  
15 agency that relates to a health care professional and  
16 information held by a participating agency that  
17 relates to a health care professional or managed care  
18 organization that is the subject of an investigation  
19 by a participating agency for alleged fraud or abuse  
20 under Medicaid.

21 (c) A participating agency may submit to another  
22 participating agency a written request for information  
23 described by Subsection (b) regarding a health care  
24 professional or managed care organization. The  
25 participating agency that receives the request shall  
26 provide the requesting agency with the information  
27 regarding the health care professional or managed care  
28 organization unless:

29 (1) the release of the information would  
30 jeopardize an ongoing investigation or prosecution by  
31 the participating agency with possession of the  
32 information; or

33 (2) the release of the information is  
34 prohibited by other law.

35 (c-1) Notwithstanding any other law, a  
36 participating agency may enter into a memorandum of  
37 understanding or agreement with another participating  
38 agency for the purpose of exchanging criminal history  
39 record information relating to a health care  
40 professional that both participating agencies are  
41 authorized to access under Chapter 411. Confidential  
42 criminal history record information in the possession  
43 of a participating agency that is provided to another  
44 participating agency in accordance with this  
45 subsection remains confidential while in the  
46 possession of the participating agency that receives  
47 the information.

48 (d) A participating agency that discovers  
49 information that may indicate fraud or abuse by a  
50 health care professional or managed care organization  
51 may provide that information to any other  
52 participating agency unless the release of the  
53 information is prohibited by other law.

54 (e) Not later than the 30th day after the date  
55 the agency receives a request for information under

1 Subsection (c), a participating agency that determines  
2 the agency is prohibited from releasing the requested  
3 information shall inform the agency requesting the  
4 information of that determination in writing.

5 (f) Confidential information shared under this  
6 section remains subject to the same confidentiality  
7 requirements and legal restrictions on access to the  
8 information that are imposed by law on the  
9 participating agency that originally obtained or  
10 collected the information. The sharing of information  
11 under this section does not affect whether the  
12 information is subject to disclosure under Chapter  
13 552.

14 (g) A participating agency that receives  
15 information from another participating agency under  
16 this section must obtain written permission from the  
17 agency that shared the information before using the  
18 information in a licensure or enforcement action.

19 (h) This section does not affect the  
20 participating agencies' authority to exchange  
21 information under other law.

22 Revised Law

23 Sec. 544.0153. PROVIDER ELIGIBILITY FOR MEDICAID  
24 PARTICIPATION: CRIMINAL HISTORY RECORD INFORMATION. (a) The  
25 office of inspector general and each licensing authority that  
26 requires the submission of fingerprints to conduct a criminal  
27 history record information check of a health care professional  
28 shall enter into a memorandum of understanding to ensure that only  
29 individuals who are licensed and in good standing as health care  
30 professionals participate as Medicaid providers. The memorandum  
31 under this section may be combined with a memorandum authorized  
32 under Section 544.0152(c) and must include a process by which:

33 (1) to determine a health care professional's  
34 eligibility to participate in Medicaid, the office may confirm with  
35 a licensing authority that the professional is licensed and in good  
36 standing; and

37 (2) the licensing authority immediately notifies the  
38 office if:

39 (A) a provider's license has been revoked or  
40 suspended; or

41 (B) the licensing authority has taken  
42 disciplinary action against a provider.

43 (b) To determine a health care professional's eligibility  
44 to participate as a Medicaid provider, the office of inspector

1 general may not conduct a criminal history record information check  
2 of a health care professional who the office has confirmed under  
3 Subsection (a) is licensed and in good standing. This subsection  
4 does not prohibit the office from conducting a criminal history  
5 record information check of a provider that is required or  
6 appropriate for other reasons, including for conducting an  
7 investigation of fraud, waste, or abuse.

8 (c) To determine a provider's eligibility to participate in  
9 Medicaid and subject to Subsection (d), the office of inspector  
10 general, after seeking public input, shall establish and the  
11 executive commissioner by rule shall adopt guidelines for  
12 evaluating criminal history record information of providers and  
13 potential providers. The guidelines must outline conduct, by  
14 provider type, that may be contained in criminal history record  
15 information that will result in excluding a person as a Medicaid  
16 provider, taking into consideration:

17 (1) the extent to which the underlying conduct relates  
18 to the services provided through Medicaid;

19 (2) the degree to which the person would interact with  
20 Medicaid recipients as a provider; and

21 (3) any previous evidence that the person engaged in  
22 Medicaid fraud, waste, or abuse.

23 (d) The guidelines adopted under Subsection (c) may not  
24 impose stricter standards for an individual's eligibility to  
25 participate in Medicaid than a licensing authority described by  
26 Subsection (a) requires for the individual to engage in a health  
27 care profession without restriction in this state.

28 (e) The office of inspector general and the commission shall  
29 use the guidelines the executive commissioner adopts under  
30 Subsection (c) to determine whether a Medicaid provider continues  
31 to be eligible to participate as a Medicaid provider.

32 (f) The provider enrollment contractor, if applicable, and  
33 a Medicaid managed care organization shall defer to the office of  
34 inspector general on whether an individual's criminal history

1 record information precludes the individual from participating as a  
2 Medicaid provider. (Gov. Code, Secs. 531.1032(a), (b), (c), as  
3 added Acts 84th Leg., R.S., Ch. 945, (d), (e), (f).)

4 Source Law

5 Sec. 531.1032. OFFICE OF INSPECTOR GENERAL:  
6 CRIMINAL HISTORY RECORD INFORMATION CHECK. (a) The  
7 office and each licensing authority that requires the  
8 submission of fingerprints for the purpose of  
9 conducting a criminal history record information check  
10 of a health care professional shall enter into a  
11 memorandum of understanding to ensure that only  
12 persons who are licensed and in good standing as health  
13 care professionals participate as providers in  
14 Medicaid. The memorandum under this section may be  
15 combined with a memorandum authorized under Section  
16 531.1031(c-1) and must include a process by which:

17 (1) the office may confirm with a  
18 licensing authority that a health care professional is  
19 licensed and in good standing for purposes of  
20 determining eligibility to participate in Medicaid;  
21 and

22 (2) the licensing authority immediately  
23 notifies the office if:

24 (A) a provider's license has been  
25 revoked or suspended; or

26 (B) the licensing authority has taken  
27 disciplinary action against a provider.

28 (b) The office may not, for purposes of  
29 determining a health care professional's eligibility  
30 to participate in Medicaid as a provider, conduct a  
31 criminal history record information check of a health  
32 care professional who the office has confirmed under  
33 Subsection (a) is licensed and in good standing. This  
34 subsection does not prohibit the office from  
35 performing a criminal history record information check  
36 of a provider that is required or appropriate for other  
37 reasons, including for conducting an investigation of  
38 fraud, waste, or abuse.

39 (c) For purposes of determining eligibility to  
40 participate in Medicaid and subject to Subsection (d),  
41 the office, after seeking public input, shall  
42 establish and the executive commissioner by rule shall  
43 adopt guidelines for the evaluation of criminal  
44 history record information of providers and potential  
45 providers. The guidelines must outline conduct, by  
46 provider type, that may be contained in criminal  
47 history record information that will result in  
48 exclusion of a person from Medicaid as a provider,  
49 taking into consideration:

50 (1) the extent to which the underlying  
51 conduct relates to the services provided under  
52 Medicaid;

53 (2) the degree to which the person would  
54 interact with Medicaid recipients as a provider; and

55 (3) any previous evidence that the person  
56 engaged in fraud, waste, or abuse under Medicaid.

57 (d) The guidelines adopted under Subsection (c)  
58 may not impose stricter standards for the eligibility  
59 of a person to participate in Medicaid than a licensing  
60 authority described by Subsection (a) requires for the  
61 person to engage in a health care profession without  
62 restriction in this state.

63 (e) The office and the commission shall use the

1 guidelines adopted under Subsection (c) to determine  
2 whether a provider participating in Medicaid continues  
3 to be eligible to participate in Medicaid as a  
4 provider.

5 (f) The provider enrollment contractor, if  
6 applicable, and a managed care organization  
7 participating in Medicaid shall defer to the office  
8 regarding whether a person's criminal history record  
9 information precludes the person from participating in  
10 Medicaid as a provider.

11 Revisor's Note

12 (1) Section 531.1032(c), Government Code, as  
13 added by Section 2.15(b), Chapter 837 (S.B. 200), Acts  
14 of the 84th Legislature, Regular Session, 2015,  
15 requires the Health and Human Services Commission's  
16 office of inspector general, after seeking public  
17 input from various geographic areas across this state  
18 in person or through teleconferencing centers, to  
19 establish guidelines for evaluating certain criminal  
20 history record information. Section 531.1032(c),  
21 Government Code, as added by Section 5, Chapter 945  
22 (S.B. 207), Acts of the 84th Legislature, Regular  
23 Session, 2015, imposes the same duties on the office,  
24 except that the office is not required to seek public  
25 input from various geographic areas across this state  
26 in person or through teleconferencing centers.  
27 Because Section 531.1032(c), as added by Chapter 837,  
28 is more specific in its requirements than Section  
29 531.1032(c), as added by Chapter 945, the statutes are  
30 irreconcilable. Under Section 311.025(a), Government  
31 Code (Code Construction Act), if statutes enacted at  
32 the same or different sessions of the legislature are  
33 irreconcilable, the statute latest in date of  
34 enactment prevails. Under Section 311.025(d),  
35 Government Code (Code Construction Act), the date of  
36 enactment is the date on which the last legislative  
37 vote is taken on the bill enacting the statute. The  
38 last legislative vote on Chapter 837 was taken May 28,  
39 2015. The last legislative vote on Chapter 945 was

1 taken May 30, 2015. Accordingly, the revised law omits  
2 Section 531.1032(c), as added by Chapter 837, as  
3 superseded by Section 531.1032(c), as added by Chapter  
4 945. The omitted law reads:

5 (c) For purposes of determining  
6 eligibility to participate in Medicaid and  
7 subject to Subsection (d), the office,  
8 after seeking public input from various  
9 geographic areas across this state, either  
10 in person or through teleconferencing  
11 centers, shall establish and the executive  
12 commissioner by rule shall adopt guidelines  
13 for the evaluation of criminal history  
14 record information of providers and  
15 potential providers. The guidelines must  
16 outline conduct, by provider type, that may  
17 be contained in criminal history record  
18 information that will result in exclusion  
19 of a person from Medicaid as a provider,  
20 taking into consideration:

21 (1) the extent to which the  
22 underlying conduct relates to the services  
23 provided under Medicaid;

24 (2) the degree to which the  
25 person would interact with Medicaid  
26 recipients as a provider; and

27 (3) any previous evidence that  
28 the person engaged in fraud, waste, or abuse  
29 under Medicaid.

30 (2) Section 531.1032(f), Government Code,  
31 refers to a "managed care organization participating  
32 in Medicaid." The revised law substitutes "Medicaid  
33 managed care organization" for "managed care  
34 organization participating in Medicaid" for the reason  
35 stated in the revisor's note to Section 544.0109 of  
36 this chapter.

#### 37 Revised Law

38 Sec. 544.0154. MONITORING OF CERTAIN FEDERAL DATABASES.  
39 The office of inspector general shall routinely check appropriate  
40 federal databases, including databases referenced in 42 C.F.R.  
41 Section 455.436, to ensure that a person excluded by the federal  
42 government from participating in Medicaid or Medicare is not  
43 participating as a Medicaid provider. (Gov. Code, Sec. 531.1033.)

#### 44 Source Law

45 Sec. 531.1033. MONITORING OF CERTAIN FEDERAL  
46 DATABASES. The office shall routinely check  
47 appropriate federal databases, including databases

1 referenced in 42 C.F.R. Section 455.436, to ensure  
2 that a person who is excluded from participating in  
3 Medicaid or in the Medicare program by the federal  
4 government is not participating as a provider in  
5 Medicaid.

6 Revised Law

7 Sec. 544.0155. PERIOD FOR DETERMINING PROVIDER ELIGIBILITY  
8 FOR MEDICAID. (a) Not later than the 10th day after the date the  
9 office of inspector general receives a health care professional's  
10 complete application seeking to participate in Medicaid, the office  
11 shall inform the commission or the health care professional, as  
12 appropriate, of the office's determination of whether the health  
13 care professional should be denied participation in Medicaid based  
14 on:

15 (1) information concerning the health care  
16 professional's licensing status obtained as described by Section  
17 544.0153(a);

18 (2) information contained in the criminal history  
19 record information check that is evaluated in accordance with  
20 guidelines the executive commissioner adopts under Section  
21 544.0153(c);

22 (3) a review of federal databases under Section  
23 544.0154;

24 (4) the pendency of an open investigation by the  
25 office; or

26 (5) any other reason the office determines  
27 appropriate.

28 (b) Completion of an on-site visit of a health care  
29 professional during the period prescribed by Subsection (a) is not  
30 required.

31 (c) The office of inspector general shall develop  
32 performance metrics to measure the length of time for conducting a  
33 determination described by Subsection (a) with respect to:

34 (1) applications that are complete when submitted; and

35 (2) all other applications. (Gov. Code, Sec.  
36 531.1034.)

1 Source Law

2 Sec. 531.1034. TIME TO DETERMINE PROVIDER  
3 ELIGIBILITY; PERFORMANCE METRICS. (a) Not later than  
4 the 10th day after the date the office receives the  
5 complete application of a health care professional  
6 seeking to participate in Medicaid, the office shall  
7 inform the commission or the health care professional,  
8 as appropriate, of the office's determination  
9 regarding whether the health care professional should  
10 be denied participation in Medicaid based on:

11 (1) information concerning the licensing  
12 status of the health care professional obtained as  
13 described by Section 531.1032(a);

14 (2) information contained in the criminal  
15 history record information check that is evaluated in  
16 accordance with guidelines adopted under Section  
17 531.1032(c);

18 (3) a review of federal databases under  
19 Section 531.1033;

20 (4) the pendency of an open investigation  
21 by the office; or

22 (5) any other reason the office determines  
23 appropriate.

24 (b) Completion of an on-site visit of a health  
25 care professional during the period prescribed by  
26 Subsection (a) is not required.

27 (c) The office shall develop performance  
28 metrics to measure the length of time for conducting a  
29 determination described by Subsection (a) with respect  
30 to applications that are complete when submitted and  
31 all other applications.

32 SUBCHAPTER E. PREVENTION AND DETECTION OF FRAUD, WASTE, AND ABUSE

33 Revised Law

34 Sec. 544.0201. SELECTION AND REVIEW OF MEDICAID CLAIMS TO  
35 DETERMINE RESOURCE ALLOCATION. (a) The commission shall annually  
36 select and review a random, statistically valid sample of all  
37 claims for Medicaid reimbursement, including under the vendor drug  
38 program, for potential cases of fraud, waste, or abuse.

39 (b) In conducting the annual review of claims, the  
40 commission may directly contact a recipient by telephone, in  
41 person, or both to verify that the services for which a provider  
42 submitted a reimbursement claim were actually provided to the  
43 recipient.

44 (c) Based on the results of the annual review of claims, the  
45 commission shall determine the types of claims toward which  
46 commission resources for fraud and abuse detection should be  
47 primarily directed.

48 (d) Absent an allegation of fraud, waste, or abuse, the

1 commission may conduct an annual review of claims only after the  
2 commission completes the prior year's annual review of claims.  
3 (Gov. Code, Sec. 531.109.)

4 Source Law

5 Sec. 531.109. SELECTION AND REVIEW OF CLAIMS.  
6 (a) The commission shall annually select and review a  
7 random, statistically valid sample of all claims for  
8 reimbursement under Medicaid, including under the  
9 vendor drug program, for potential cases of fraud,  
10 waste, or abuse.

11 (b) In conducting the annual review of claims  
12 under Subsection (a), the commission may directly  
13 contact a recipient by telephone or in person, or both,  
14 to verify that the services for which a claim for  
15 reimbursement was submitted by a provider were  
16 actually provided to the recipient.

17 (c) Based on the results of the annual review of  
18 claims, the commission shall determine the types of  
19 claims at which commission resources for fraud and  
20 abuse detection should be primarily directed.

21 (d) Absent an allegation of fraud, waste, or  
22 abuse, the commission may conduct an annual review of  
23 claims under this section only after the commission  
24 has completed the prior year's annual review of claims.

25 Revised Law

26 Sec. 544.0202. DUTIES RELATED TO FRAUD PREVENTION. (a) The  
27 office of inspector general shall compile and disseminate accurate  
28 information and statistics relating to:

29 (1) fraud prevention; and

30 (2) post-fraud referrals received and accepted or  
31 rejected from the commission's or a health and human services  
32 agency's case management system.

33 (b) The commission shall:

34 (1) aggressively publicize successful fraud  
35 prosecutions and fraud-prevention programs through all available  
36 means, including the use of statewide press releases; and

37 (2) ensure that the commission or a health and human  
38 services agency maintains and promotes a toll-free telephone  
39 hotline for reporting suspected fraud in programs the commission or  
40 a health and human services agency administers.

41 (c) The commission shall develop a cost-effective method to  
42 identify applicants for public assistance in counties bordering  
43 other states and in metropolitan areas the commission selects who

1 are already receiving benefits in other states. If economically  
2 feasible, the commission may develop a computerized matching  
3 system.

4 (d) The commission shall:

5 (1) verify automobile information that is used as  
6 eligibility criteria; and

7 (2) establish with the Texas Department of Criminal  
8 Justice a computerized matching system to prevent an incarcerated  
9 individual from illegally receiving public assistance benefits the  
10 commission administers.

11 (e) Not later than October 1 of each year, the commission  
12 shall submit to the governor and Legislative Budget Board a report  
13 on the results of computerized matching of commission information  
14 with information from neighboring states, if any, and information  
15 from the Texas Department of Criminal Justice. The commission may  
16 consolidate the report with any other report relating to the same  
17 subject matter the commission is required to submit under other  
18 law.

19 (f) The commission and each health and human services agency  
20 that administers part of Medicaid shall maintain statistics on the  
21 number, type, and disposition of fraudulent benefits claims  
22 submitted under the part of the program the agency administers.

23 (Gov. Code, Secs. 531.0215, 531.108.)

24 Source Law

25 Sec. 531.0215. COMPILATION OF STATISTICS  
26 RELATING TO FRAUD. The commission and each health and  
27 human services agency that administers a part of  
28 Medicaid shall maintain statistics on the number,  
29 type, and disposition of fraudulent claims for  
30 benefits submitted under the part of the program the  
31 agency administers.

32 Sec. 531.108. FRAUD PREVENTION. (a) The  
33 commission's office of inspector general shall compile  
34 and disseminate accurate information and statistics  
35 relating to:

36 (1) fraud prevention; and  
37 (2) post-fraud referrals received and  
38 accepted or rejected from the commission's case  
39 management system or the case management system of a  
40 health and human services agency.

41 (b) The commission shall:

42 (1) aggressively publicize successful

1 fraud prosecutions and fraud-prevention programs  
2 through all available means, including the use of  
3 statewide press releases; and

4 (2) ensure that a toll-free hotline for  
5 reporting suspected fraud in programs administered by  
6 the commission or a health and human services agency is  
7 maintained and promoted, either by the commission or  
8 by a health and human services agency.

9 (c) The commission shall develop a  
10 cost-effective method of identifying applicants for  
11 public assistance in counties bordering other states  
12 and in metropolitan areas selected by the commission  
13 who are already receiving benefits in other states. If  
14 economically feasible, the commission may develop a  
15 computerized matching system.

16 (d) The commission shall:

17 (1) verify automobile information that is  
18 used as criteria for eligibility; and

19 (2) establish a computerized matching  
20 system with the Texas Department of Criminal Justice  
21 to prevent an incarcerated individual from illegally  
22 receiving public assistance benefits administered by  
23 the commission.

24 (e) Not later than October 1 of each year, the  
25 commission shall submit to the governor and  
26 Legislative Budget Board an annual report on the  
27 results of computerized matching of commission  
28 information with information from neighboring states,  
29 if any, and information from the Texas Department of  
30 Criminal Justice. The report may be consolidated with  
31 any other report relating to the same subject matter  
32 the commission is required to submit under other law.

### 33 Revised Law

34 Sec. 544.0203. FRAUD, WASTE, AND ABUSE DETECTION TRAINING.

35 (a) The commission shall develop and implement a program to provide  
36 annual training on identifying potential cases of Medicaid fraud,  
37 waste, or abuse to:

38 (1) contractors who process Medicaid claims; and

39 (2) appropriate health and human services agency  
40 staff.

41 (b) The training must include clear criteria that specify:

42 (1) the circumstances under which a person should  
43 refer a potential case to the commission; and

44 (2) the time by which a referral should be made. (Gov.  
45 Code, Sec. 531.105(a).)

### 46 Source Law

47 Sec. 531.105. FRAUD DETECTION TRAINING. (a)  
48 The commission shall develop and implement a program  
49 to provide annual training to contractors who process  
50 Medicaid claims and to appropriate staff of the health  
51 and human services agencies in identifying potential  
52 cases of fraud, waste, or abuse under Medicaid. The  
53 training provided to the contractors and staff must

1 include clear criteria that specify:  
2 (1) the circumstances under which a person  
3 should refer a potential case to the commission; and  
4 (2) the time by which a referral should be  
5 made.

6 Revised Law

7 Sec. 544.0204. HEALTH AND HUMAN SERVICES AGENCY MEDICAID  
8 FRAUD, WASTE, AND ABUSE DETECTION GOAL. (a) The health and human  
9 services agencies, in cooperation with the commission, shall  
10 periodically set a goal for the number of potential cases of  
11 Medicaid fraud, waste, or abuse that each agency will attempt to  
12 identify and refer to the commission.

13 (b) The commission shall include in the report required by  
14 Section 544.0051(f) information on the health and human services  
15 agencies' goals and the success of each agency in meeting the  
16 agency's goal. (Gov. Code, Sec. 531.105(b).)

17 Source Law

18 (b) The health and human services agencies, in  
19 cooperation with the commission, shall periodically  
20 set a goal of the number of potential cases of fraud,  
21 waste, or abuse under Medicaid that each agency will  
22 attempt to identify and refer to the commission. The  
23 commission shall include information on the agencies'  
24 goals and the success of each agency in meeting the  
25 agency's goal in the report required by Section  
26 531.103(c).

27 Revised Law

28 Sec. 544.0205. AWARD FOR REPORTING MEDICAID FRAUD, ABUSE,  
29 OR OVERCHARGES. (a) The commission may grant an award to an  
30 individual who reports activity that constitutes fraud or abuse of  
31 Medicaid money or who reports Medicaid overcharges if the  
32 commission determines that the disclosure results in the recovery  
33 of an administrative penalty imposed under Section 32.039, Human  
34 Resources Code. The commission may not grant an award to an  
35 individual in connection with a report if the commission or  
36 attorney general had independent knowledge of the activity the  
37 individual reported.

38 (b) The commission shall determine the amount of an award.  
39 The award may not exceed five percent of the amount of the  
40 administrative penalty imposed under Section 32.039, Human

1 Resources Code, that resulted from the individual's disclosure. In  
2 determining the award amount, the commission:

3 (1) shall consider how important the disclosure is in  
4 ensuring the fiscal integrity of Medicaid; and

5 (2) may consider whether the individual participated  
6 in the fraud, abuse, or overcharge.

7 (c) An individual who brings an action under Subchapter C,  
8 Chapter 36, Human Resources Code, is not eligible for an award under  
9 this section. (Gov. Code, Sec. 531.101.)

10 Source Law

11 Sec. 531.101. AWARD FOR REPORTING MEDICAID  
12 FRAUD, ABUSE, OR OVERCHARGES. (a) The commission may  
13 grant an award to an individual who reports activity  
14 that constitutes fraud or abuse of funds in Medicaid or  
15 reports overcharges in Medicaid if the commission  
16 determines that the disclosure results in the recovery  
17 of an administrative penalty imposed under Section  
18 32.039, Human Resources Code. The commission may not  
19 grant an award to an individual in connection with a  
20 report if the commission or attorney general had  
21 independent knowledge of the activity reported by the  
22 individual.

23 (b) The commission shall determine the amount of  
24 an award. The award may not exceed five percent of the  
25 amount of the administrative penalty imposed under  
26 Section 32.039, Human Resources Code, that resulted  
27 from the individual's disclosure. In determining the  
28 amount of the award, the commission shall consider how  
29 important the disclosure is in ensuring the fiscal  
30 integrity of Medicaid. The commission may also  
31 consider whether the individual participated in the  
32 fraud, abuse, or overcharge.

33 (c) A person who brings an action under  
34 Subchapter C, Chapter 36, Human Resources Code, is not  
35 eligible for an award under this section.

36 SUBCHAPTER F. INVESTIGATION OF FRAUD, WASTE, ABUSE, AND  
37 OVERCHARGES

38 Revised Law

39 Sec. 544.0251. CLAIMS CRITERIA REQUIRING COMMENCEMENT OF  
40 INVESTIGATION. The executive commissioner, in consultation with  
41 the inspector general, by rule shall set specific claims criteria  
42 that, when met, require the office of inspector general to begin an  
43 investigation. (Gov. Code, Sec. 531.102(e).)

44 Source Law

45 (e) The executive commissioner, in consultation  
46 with the inspector general, by rule shall set specific  
47 claims criteria that, when met, require the office to

1 begin an investigation.

2 Revised Law

3 Sec. 544.0252. CIRCUMSTANCES REQUIRING COMMENCEMENT OF  
4 PRELIMINARY INVESTIGATION OF ALLEGED FRAUD OR ABUSE. (a) The  
5 office of inspector general shall conduct a preliminary  
6 investigation of an allegation of fraud or abuse against a provider  
7 that the commission receives from any source to determine whether  
8 there is a sufficient basis to warrant a full investigation. The  
9 office must begin a preliminary investigation not later than the  
10 30th day and complete the investigation not later than the 45th day  
11 after the date the commission receives or identifies an allegation  
12 of fraud or abuse.

13 (b) The office of inspector general shall conduct a  
14 preliminary investigation as provided by Section 544.0253 of a  
15 complaint or allegation of Medicaid fraud or abuse that the  
16 commission receives from any source to determine whether there is a  
17 sufficient basis to warrant a full investigation. The office must  
18 begin a preliminary investigation not later than the 30th day and  
19 complete the investigation not later than the 45th day after the  
20 date the commission receives a complaint or allegation or has  
21 reason to believe that fraud or abuse has occurred. (Gov. Code,  
22 Secs. 531.102(f)(1), 531.118(b).)

23 Source Law

24 [Sec. 531.102]

25 (f)(1) If the commission receives a complaint or  
26 allegation of Medicaid fraud or abuse from any source,  
27 the office must conduct a preliminary investigation as  
28 provided by Section 531.118(c) to determine whether  
29 there is a sufficient basis to warrant a full  
30 investigation. A preliminary investigation must begin  
31 not later than the 30th day, and be completed not later  
32 than the 45th day, after the date the commission  
33 receives a complaint or allegation or has reason to  
34 believe that fraud or abuse has occurred.

35 [Sec. 531.118]

36 (b) If the commission receives an allegation of  
37 fraud or abuse against a provider from any source, the  
38 commission's office of inspector general shall conduct  
39 a preliminary investigation of the allegation to  
40 determine whether there is a sufficient basis to  
41 warrant a full investigation. A preliminary  
42 investigation must begin not later than the 30th day,  
43 and be completed not later than the 45th day, after the  
44 date the commission receives or identifies an

1 allegation of fraud or abuse.

2 Revised Law

3 Sec. 544.0253. CONDUCT OF PRELIMINARY INVESTIGATION OF  
4 ALLEGED FRAUD OR ABUSE. In conducting a preliminary investigation  
5 of an allegation of fraud or abuse and before the allegation may  
6 proceed to a full investigation, the office of inspector general  
7 must:

8 (1) review the allegation and all facts and evidence  
9 relating to the allegation; and

10 (2) prepare a preliminary investigation report that  
11 documents:

12 (A) the allegation;

13 (B) the evidence the office reviewed, if  
14 available;

15 (C) the procedures the office used to conduct the  
16 preliminary investigation;

17 (D) the preliminary investigation findings; and

18 (E) the office's determination of whether a full  
19 investigation is warranted. (Gov. Code, Sec. 531.118(c).)

20 Source Law

21 (c) In conducting a preliminary investigation,  
22 the office must review the allegations of fraud or  
23 abuse and all facts and evidence relating to the  
24 allegation and must prepare a preliminary  
25 investigation report before the allegation of fraud or  
26 abuse may proceed to a full investigation. The  
27 preliminary investigation report must document the  
28 allegation, the evidence reviewed, if available, the  
29 procedures used to conduct the preliminary  
30 investigation, the findings of the preliminary  
31 investigation, and the office's determination of  
32 whether a full investigation is warranted.

33 Revised Law

34 Sec. 544.0254. FINDING OF CERTAIN MEDICAID FRAUD OR ABUSE  
35 FOLLOWING PRELIMINARY INVESTIGATION: CRIMINAL REFERRAL OR FULL  
36 INVESTIGATION. If the findings of a preliminary investigation give  
37 the office of inspector general reason to believe that an incident  
38 of Medicaid fraud or abuse involving possible criminal conduct has  
39 occurred, not later than the 30th day after completing the  
40 preliminary investigation, the office, as appropriate:

1 (1) must refer the case to this state's Medicaid fraud  
2 control unit if a provider is suspected of fraud or abuse involving  
3 criminal conduct, provided that the criminal referral does not  
4 preclude the office from continuing the office's investigation of  
5 the provider that may lead to the imposition of appropriate  
6 administrative or civil sanctions; or

7 (2) may conduct a full investigation, subject to  
8 Section 544.0253, if there is reason to believe that a recipient has  
9 defrauded Medicaid. (Gov. Code, Sec. 531.102(f)(2).)

10 Source Law

11 (2) If the findings of a preliminary  
12 investigation give the office reason to believe that  
13 an incident of fraud or abuse involving possible  
14 criminal conduct has occurred in Medicaid, the office  
15 must take the following action, as appropriate, not  
16 later than the 30th day after the completion of the  
17 preliminary investigation:

18 (A) if a provider is suspected of  
19 fraud or abuse involving criminal conduct, the office  
20 must refer the case to the state's Medicaid fraud  
21 control unit, provided that the criminal referral does  
22 not preclude the office from continuing its  
23 investigation of the provider, which investigation may  
24 lead to the imposition of appropriate administrative  
25 or civil sanctions; or

26 (B) if there is reason to believe  
27 that a recipient has defrauded Medicaid, the office  
28 may conduct a full investigation of the suspected  
29 fraud, subject to Section 531.118(c).

30 Revised Law

31 Sec. 544.0255. IMMEDIATE CRIMINAL REFERRAL UNDER CERTAIN  
32 CIRCUMSTANCES. If the office of inspector general learns or has  
33 reason to suspect that a provider's records are being withheld,  
34 concealed, destroyed, fabricated, or in any way falsified, the  
35 office shall immediately refer the case to this state's Medicaid  
36 fraud control unit. The criminal referral does not preclude the  
37 office from continuing the office's investigation of the provider  
38 that may lead to the imposition of appropriate administrative or  
39 civil sanctions. (Gov. Code, Sec. 531.102(g)(1).)

40 Source Law

41 (g)(1) Whenever the office learns or has reason  
42 to suspect that a provider's records are being  
43 withheld, concealed, destroyed, fabricated, or in any  
44 way falsified, the office shall immediately refer the  
45 case to the state's Medicaid fraud control unit.



1 continued until:

2 (1) that investigation and any associated  
3 enforcement proceedings are complete; or

4 (2) the state's Medicaid fraud control  
5 unit, another law enforcement agency, or other  
6 prosecuting authorities determine that there is  
7 insufficient evidence of fraud by the provider.

8 (e) If the state's Medicaid fraud control unit  
9 or any other law enforcement agency declines to accept  
10 a fraud referral from the office for investigation, a  
11 payment hold based on a credible allegation of fraud  
12 must be discontinued unless the commission has  
13 alternative federal or state authority under which it  
14 may impose a payment hold or the office makes a fraud  
15 referral to another law enforcement agency.

16 (f) On a quarterly basis, the office must  
17 request a certification from the state's Medicaid  
18 fraud control unit and other law enforcement agencies  
19 as to whether each matter accepted by the unit or  
20 agency on the basis of a credible allegation of fraud  
21 referral continues to be under investigation and that  
22 the continuation of the payment hold is warranted.

23 Revisor's Note

24 Section 531.118(f), Government Code, provides  
25 that the Health and Human Services Commission's office  
26 of inspector general "must" request a certification of  
27 certain information. The revised law substitutes  
28 "shall" for "must" because under Section 311.016,  
29 Government Code (Code Construction Act), applicable to  
30 the revised law, the term "shall" imposes a duty on an  
31 actor, and it is clear that requesting the  
32 certification is a duty imposed on the office of  
33 inspector general.

34 Revised Law

35 Sec. 544.0257. COMPLETION OF FULL INVESTIGATION OF ALLEGED  
36 MEDICAID FRAUD OR ABUSE. (a) The office of inspector general shall  
37 complete a full investigation of a complaint or allegation of  
38 Medicaid fraud or abuse against a provider not later than the 180th  
39 day after the date the full investigation begins unless the office  
40 determines that more time is needed to complete the investigation.

41 (b) Except as otherwise provided by this subsection, if the  
42 office of inspector general determines that more time is needed to  
43 complete a full investigation, the office shall provide notice to  
44 the provider who is the subject of the investigation stating that  
45 the length of the investigation will exceed 180 days and specifying

1 the reasons why the office was unable to complete the investigation  
2 within the 180-day period. The office is not required to provide  
3 notice to the provider under this subsection if the office  
4 determines that providing notice would jeopardize the  
5 investigation. (Gov. Code, Sec. 531.102(f-1).)

6 Source Law

7 (f-1) The office shall complete a full  
8 investigation of a complaint or allegation of Medicaid  
9 fraud or abuse against a provider not later than the  
10 180th day after the date the full investigation begins  
11 unless the office determines that more time is needed  
12 to complete the investigation. Except as otherwise  
13 provided by this subsection, if the office determines  
14 that more time is needed to complete the  
15 investigation, the office shall provide notice to the  
16 provider who is the subject of the investigation  
17 stating that the length of the investigation will  
18 exceed 180 days and specifying the reasons why the  
19 office was unable to complete the investigation within  
20 the 180-day period. The office is not required to  
21 provide notice to the provider under this subsection  
22 if the office determines that providing notice would  
23 jeopardize the investigation.

24 Revised Law

25 Sec. 544.0258. MEMORANDUM OF UNDERSTANDING FOR ASSISTING  
26 ATTORNEY GENERAL INVESTIGATIONS RELATED TO MEDICAID. (a) The  
27 commission and the attorney general shall enter into a memorandum  
28 of understanding under which the commission shall:

29 (1) provide investigative support to the attorney  
30 general as required in connection with cases under Subchapter B,  
31 Chapter 36, Human Resources Code; and

32 (2) assist in performing preliminary investigations  
33 and ongoing investigations for actions the attorney general  
34 prosecutes under Subchapter C, Chapter 36, Human Resources Code.

35 (b) The memorandum of understanding must specify the type,  
36 scope, and format of the investigative support the commission  
37 provides to the attorney general.

38 (c) The memorandum of understanding must ensure that  
39 barriers to direct fraud referrals to this state's Medicaid fraud  
40 control unit by Medicaid agencies or unreasonable impediments to  
41 communication between Medicaid agency employees and the Medicaid  
42 fraud control unit are not imposed. (Gov. Code, Sec. 531.104.)



1 auditor's office, law enforcement agencies, and other entities as  
2 permitted by other law, all information and materials subpoenaed or  
3 compiled by the office of inspector general in connection with an  
4 audit, inspection, or investigation or by the office of the  
5 attorney general in connection with a Medicaid fraud investigation  
6 are:

7 (1) confidential and not subject to disclosure under  
8 Chapter 552; and

9 (2) not subject to disclosure, discovery, subpoena, or  
10 other means of legal compulsion for release to anyone other than the  
11 office of inspector general, the attorney general, or the office's  
12 or attorney general's employees or agents involved in the audit,  
13 inspection, or investigation.

14 (f) A person who receives information under Subsection (e)  
15 may disclose the information only in accordance with Subsection (e)  
16 and in a manner that is consistent with the authorized purpose for  
17 which the person first received the information. (Gov. Code, Sec.  
18 531.1021.)

19 Source Law

20 Sec. 531.1021. SUBPOENAS. (a) The office of  
21 inspector general may issue a subpoena in connection  
22 with an investigation conducted by the office. A  
23 subpoena may be issued under this section to compel the  
24 attendance of a relevant witness or the production,  
25 for inspection or copying, of relevant evidence that  
26 is in this state.

27 (b) A subpoena may be served personally or by  
28 certified mail.

29 (c) If a person fails to comply with a subpoena,  
30 the office, acting through the attorney general, may  
31 file suit to enforce the subpoena in a district court  
32 in this state.

33 (d) On finding that good cause exists for  
34 issuing the subpoena, the court shall order the person  
35 to comply with the subpoena. The court may punish a  
36 person who fails to obey the court order.

37 (e) The office shall pay a reasonable fee for  
38 photocopies subpoenaed under this section in an amount  
39 not to exceed the amount the office may charge for  
40 copies of its records.

41 (f) The reimbursement of the expenses of a  
42 witness whose attendance is compelled under this  
43 section is governed by Section 2001.103.

44 (g) All information and materials subpoenaed or  
45 compiled by the office in connection with an audit,  
46 inspection, or investigation or by the office of the  
47 attorney general in connection with a Medicaid fraud  
48 investigation are confidential and not subject to

1 disclosure under Chapter 552, and not subject to  
2 disclosure, discovery, subpoena, or other means of  
3 legal compulsion for their release to anyone other  
4 than the office or the attorney general or their  
5 employees or agents involved in the audit, inspection,  
6 or investigation conducted by the office or the  
7 attorney general, except that this information may be  
8 disclosed to the state auditor's office, law  
9 enforcement agencies, and other entities as permitted  
10 by other law.

11 (h) A person who receives information under  
12 Subsection (g) may disclose the information only in  
13 accordance with Subsection (g) and in a manner that is  
14 consistent with the authorized purpose for which the  
15 person first received the information.

16 SUBCHAPTER G. PAYMENT HOLDS

17 Revised Law

18 Sec. 544.0301. IMPOSITION OF PAYMENT HOLD. (a) As  
19 authorized by state and federal law and except as provided by  
20 Subsections (d) and (e), the office of inspector general shall  
21 impose, as a serious enforcement tool to mitigate ongoing financial  
22 risk to this state, a payment hold on claims for reimbursement  
23 submitted by a provider only:

24 (1) to compel production of records;

25 (2) when requested by this state's Medicaid fraud  
26 control unit; or

27 (3) on the determination that a credible allegation of  
28 fraud exists, subject to Sections 544.0104(b) and 544.0105(b), as  
29 applicable.

30 (b) The office of inspector general shall impose a payment  
31 hold under this section without prior notice, and the payment hold  
32 takes effect immediately.

33 (c) The office of inspector general shall, in consultation  
34 with this state's Medicaid fraud control unit, establish guidelines  
35 regarding the imposition of payment holds authorized under this  
36 section.

37 (d) On the determination that a credible allegation of fraud  
38 exists and in accordance with 42 C.F.R. Sections 455.23(e) and (f),  
39 the office of inspector general may find that good cause exists to  
40 not impose a payment hold, to not continue a payment hold, to impose  
41 a payment hold only in part, or to convert a payment hold imposed in

1 whole to one imposed only in part if:

2 (1) law enforcement officials specifically requested  
3 that a payment hold not be imposed because a payment hold would  
4 compromise or jeopardize an investigation;

5 (2) available remedies implemented by this state other  
6 than a payment hold would more effectively or quickly protect  
7 Medicaid money;

8 (3) the office determines, based on the submission of  
9 written evidence by the provider who is the subject of the payment  
10 hold, that the payment hold should be removed;

11 (4) Medicaid recipients' access to items or services  
12 would be jeopardized by a full or partial payment hold because the  
13 provider who is the subject of the payment hold:

14 (A) is the sole community physician or the sole  
15 source of essential specialized services in a community; or

16 (B) serves a large number of Medicaid recipients  
17 within a designated medically underserved area;

18 (5) the attorney general declines to certify that a  
19 matter continues to be under investigation; or

20 (6) the office determines that a full or partial  
21 payment hold is not in the best interests of Medicaid.

22 (e) Unless the office of inspector general has evidence that  
23 a provider materially misrepresented documentation relating to  
24 medically necessary services, the office may not impose a payment  
25 hold on claims for reimbursement the provider submits for those  
26 services if the provider obtained prior authorization from the  
27 commission or a commission contractor. (Gov. Code, Secs.  
28 531.102(g)(2) (part), (7-a), (8), (9).)

29 Source Law

30 (2) As authorized under state and federal  
31 law, and except as provided by Subdivisions (8) and  
32 (9), the office shall impose without prior notice a  
33 payment hold on claims for reimbursement submitted by  
34 a provider only to compel production of records, when  
35 requested by the state's Medicaid fraud control unit,  
36 or on the determination that a credible allegation of  
37 fraud exists, subject to Subsections (l) and (m), as  
38 applicable. The payment hold is a serious enforcement

1 tool that the office imposes to mitigate ongoing  
2 financial risk to the state. A payment hold imposed  
3 under this subdivision takes effect immediately. . . .

4 (7-a) The office shall, in consultation  
5 with the state's Medicaid fraud control unit,  
6 establish guidelines regarding the imposition of  
7 payment holds authorized under Subdivision (2).

8 (8) In accordance with 42 C.F.R. Sections  
9 455.23(e) and (f), on the determination that a  
10 credible allegation of fraud exists, the office may  
11 find that good cause exists to not impose a payment  
12 hold, to not continue a payment hold, to impose a  
13 payment hold only in part, or to convert a payment hold  
14 imposed in whole to one imposed only in part, if any of  
15 the following are applicable:

16 (A) law enforcement officials have  
17 specifically requested that a payment hold not be  
18 imposed because a payment hold would compromise or  
19 jeopardize an investigation;

20 (B) available remedies implemented  
21 by the state other than a payment hold would more  
22 effectively or quickly protect Medicaid funds;

23 (C) the office determines, based on  
24 the submission of written evidence by the provider who  
25 is the subject of the payment hold, that the payment  
26 hold should be removed;

27 (D) Medicaid recipients' access to  
28 items or services would be jeopardized by a full or  
29 partial payment hold because the provider who is the  
30 subject of the payment hold:

31 (i) is the sole community  
32 physician or the sole source of essential specialized  
33 services in a community; or

34 (ii) serves a large number of  
35 Medicaid recipients within a designated medically  
36 underserved area;

37 (E) the attorney general declines to  
38 certify that a matter continues to be under  
39 investigation; or

40 (F) the office determines that a full  
41 or partial payment hold is not in the best interests of  
42 Medicaid.

43 (9) The office may not impose a payment  
44 hold on claims for reimbursement submitted by a  
45 provider for medically necessary services for which  
46 the provider has obtained prior authorization from the  
47 commission or a contractor of the commission unless  
48 the office has evidence that the provider has  
49 materially misrepresented documentation relating to  
50 those services.

51 Revised Law

52 Sec. 544.0302. NOTICE. (a) The office of inspector general  
53 shall notify a provider of a payment hold imposed under Section  
54 544.0301(a) in accordance with 42 C.F.R. Section 455.23(b) and,  
55 except as provided by that regulation, not later than the fifth day  
56 after the date the office imposes the payment hold.

57 (b) In addition to the requirements of 42 C.F.R. Section  
58 455.23(b), the payment hold notice must also include:

- 1 (1) the specific basis for the hold, including:
- 2 (A) the claims supporting the allegation at that
- 3 point in the investigation;
- 4 (B) a representative sample of any documents that
- 5 form the basis for the hold; and
- 6 (C) a detailed summary of the office of inspector
- 7 general's evidence relating to the allegation;
- 8 (2) a description of administrative and judicial due
- 9 process rights and remedies, including:
- 10 (A) the provider's option to seek informal
- 11 resolution;
- 12 (B) the provider's right to seek a formal
- 13 administrative appeal hearing; or
- 14 (C) the provider's ability to seek both an
- 15 informal resolution and a formal administrative appeal hearing; and
- 16 (3) a detailed timeline for the provider to pursue the
- 17 rights and remedies described in Subdivision (2). (Gov. Code, Sec.
- 18 531.102(g)(2) (part).)

19 Source Law

- 20 (2) . . . The office must notify the
- 21 provider of the payment hold in accordance with 42
- 22 C.F.R. Section 455.23(b) and, except as provided by
- 23 that regulation, not later than the fifth day after the
- 24 date the office imposes the payment hold. In addition
- 25 to the requirements of 42 C.F.R. Section 455.23(b),
- 26 the notice of payment hold provided under this
- 27 subdivision must also include:
- 28 (A) the specific basis for the hold,
- 29 including identification of the claims supporting the
- 30 allegation at that point in the investigation, a
- 31 representative sample of any documents that form the
- 32 basis for the hold, and a detailed summary of the
- 33 office's evidence relating to the allegation;
- 34 (B) a description of administrative
- 35 and judicial due process rights and remedies,
- 36 including the provider's option to seek informal
- 37 resolution, the provider's right to seek a formal
- 38 administrative appeal hearing, or that the provider
- 39 may seek both; and
- 40 (C) a detailed timeline for the
- 41 provider to pursue the rights and remedies described
- 42 in Paragraph (B).

43 Revisor's Note

44 Section 531.102(g)(2), Government Code,

45 specifies that the Health and Human Services

1 Commission's office of inspector general "must" notify  
2 a provider of a payment hold. The revised law  
3 substitutes "shall" for "must" for the reason stated  
4 in the revisor's note to Section 544.0256 of this  
5 chapter.

6 Revised Law

7 Sec. 544.0303. EXPEDITED ADMINISTRATIVE HEARING. (a) A  
8 provider subject to a payment hold imposed under Section  
9 544.0301(a), other than a hold this state's Medicaid fraud control  
10 unit requested, must request an expedited administrative hearing  
11 not later than the 10th day after the date the provider receives  
12 notice of the hold from the office of inspector general under  
13 Section 544.0302.

14 (b) On a provider's timely written request, the office of  
15 inspector general shall, not later than the third day after the date  
16 the office receives the request, file a request with the State  
17 Office of Administrative Hearings for an expedited administrative  
18 hearing regarding the payment hold for which the provider submitted  
19 the request.

20 (c) Not later than the 45th day after the date the State  
21 Office of Administrative Hearings receives a request from the  
22 office of inspector general for an expedited administrative  
23 hearing, the State Office of Administrative Hearings shall hold the  
24 hearing.

25 (d) In an expedited administrative hearing held under this  
26 section:

27 (1) the provider and the office of inspector general  
28 are each limited to four hours of testimony, excluding time for  
29 responding to questions from the administrative law judge;

30 (2) the provider and the office are each entitled to  
31 two continuances under reasonable circumstances; and

32 (3) the office is required to show probable cause  
33 that:

34 (A) the credible allegation of fraud that is the

1 basis of the imposed payment hold has an indicia of reliability; and

2 (B) continuing to pay the provider presents an  
3 ongoing significant financial risk to this state and a threat to the  
4 integrity of Medicaid.

5 (e) The office of inspector general is responsible for the  
6 costs of the expedited administrative hearing, but a provider is  
7 responsible for the provider's own costs incurred in preparing for  
8 the hearing.

9 (f) In the expedited administrative hearing, the  
10 administrative law judge shall decide whether the payment hold  
11 should continue but may not adjust the amount or percent of the  
12 payment hold.

13 (g) Notwithstanding any other law, including Section  
14 2001.058(e), the administrative law judge's decision in the  
15 expedited administrative hearing is final and may not be appealed.  
16 (Gov. Code, Secs. 531.102(g)(3), (4), (5).)

17 Source Law

18 (3) On timely written request by a  
19 provider subject to a payment hold under Subdivision  
20 (2), other than a hold requested by the state's  
21 Medicaid fraud control unit, the office shall file a  
22 request with the State Office of Administrative  
23 Hearings for an expedited administrative hearing  
24 regarding the hold not later than the third day after  
25 the date the office receives the provider's request.  
26 The provider must request an expedited administrative  
27 hearing under this subdivision not later than the 10th  
28 day after the date the provider receives notice from  
29 the office under Subdivision (2). The State Office of  
30 Administrative Hearings shall hold the expedited  
31 administrative hearing not later than the 45th day  
32 after the date the State Office of Administrative  
33 Hearings receives the request for the hearing. In a  
34 hearing held under this subdivision:

35 (A) the provider and the office are  
36 each limited to four hours of testimony, excluding  
37 time for responding to questions from the  
38 administrative law judge;

39 (B) the provider and the office are  
40 each entitled to two continuances under reasonable  
41 circumstances; and

42 (C) the office is required to show  
43 probable cause that the credible allegation of fraud  
44 that is the basis of the payment hold has an indicia of  
45 reliability and that continuing to pay the provider  
46 presents an ongoing significant financial risk to the  
47 state and a threat to the integrity of Medicaid.

48 (4) The office is responsible for the  
49 costs of a hearing held under Subdivision (3), but a  
50 provider is responsible for the provider's own costs

1 incurred in preparing for the hearing.

2 (5) In a hearing held under Subdivision  
3 (3), the administrative law judge shall decide if the  
4 payment hold should continue but may not adjust the  
5 amount or percent of the payment hold.  
6 Notwithstanding any other law, including Section  
7 2001.058(e), the decision of the administrative law  
8 judge is final and may not be appealed.

9 Revisor's Note

10 (1) Section 531.102(g)(3), Government Code,  
11 refers to the imposition of a payment hold under  
12 Subdivision (2), meaning Section 531.102(g)(2),  
13 Government Code. The provision of Section  
14 531.102(g)(2) related to imposing a payment hold is  
15 revised in this chapter as Section 544.030(a), and the  
16 revised law is drafted accordingly.

17 (2) Section 531.102(g)(3), Government Code,  
18 refers to a provider's receipt of notice under  
19 Subdivision (2), meaning Section 531.102(g)(2),  
20 Government Code. The provision of Section  
21 531.102(g)(2) related to a provider's receipt of  
22 notice is revised in this chapter as Section 544.0302,  
23 and the revised law is drafted accordingly.

24 Revised Law

25 Sec. 544.0304. INFORMAL RESOLUTION. (a) The executive  
26 commissioner, in consultation with the office of inspector general,  
27 shall adopt rules that allow a provider subject to a payment hold  
28 imposed under Section 544.0301(a), other than a hold this state's  
29 Medicaid fraud control unit requested, to seek an informal  
30 resolution of the issues the office identifies in the notice  
31 provided under Section 544.0302.

32 (b) A provider must request an initial informal resolution  
33 meeting under this section not later than the deadline prescribed  
34 by Section 544.0303(a) for requesting an expedited administrative  
35 hearing.

36 (c) On receipt of a timely request, the office of inspector  
37 general shall:

38 (1) decide whether to grant the provider's request for

1 an initial informal resolution meeting; and

2 (2) if the office decides to grant the request,  
3 schedule the initial informal resolution meeting and give notice to  
4 the provider of the time and place of the meeting.

5 (d) A provider may request a second informal resolution  
6 meeting after the date of an initial informal resolution meeting.  
7 On receipt of a timely request, the office of inspector general  
8 shall:

9 (1) decide whether to grant the provider's request for  
10 a second informal resolution meeting; and

11 (2) if the office decides to grant the request,  
12 schedule the second informal resolution meeting and give notice to  
13 the provider of the time and place of the second meeting.

14 (e) Before a second informal resolution meeting is held, a  
15 provider must have an opportunity to provide additional information  
16 for the office of inspector general to consider.

17 (f) A provider's decision to seek an informal resolution  
18 under this section does not extend the time by which the provider  
19 must request an expedited administrative hearing under Section  
20 544.0303(a). The informal resolution process shall run  
21 concurrently with the administrative hearing process, and the  
22 informal resolution process shall be discontinued when the State  
23 Office of Administrative Hearings issues a final determination on  
24 the payment hold. (Gov. Code, Sec. 531.102(g)(6).)

25 Source Law

26 (6) The executive commissioner, in  
27 consultation with the office, shall adopt rules that  
28 allow a provider subject to a payment hold under  
29 Subdivision (2), other than a hold requested by the  
30 state's Medicaid fraud control unit, to seek an  
31 informal resolution of the issues identified by the  
32 office in the notice provided under that subdivision.  
33 A provider must request an initial informal resolution  
34 meeting under this subdivision not later than the  
35 deadline prescribed by Subdivision (3) for requesting  
36 an expedited administrative hearing. On receipt of a  
37 timely request, the office shall decide whether to  
38 grant the provider's request for an initial informal  
39 resolution meeting, and if the office decides to grant  
40 the request, the office shall schedule the initial  
41 informal resolution meeting. The office shall give  
42 notice to the provider of the time and place of the

1 initial informal resolution meeting. A provider may  
2 request a second informal resolution meeting after the  
3 date of the initial informal resolution meeting. On  
4 receipt of a timely request, the office shall decide  
5 whether to grant the provider's request for a second  
6 informal resolution meeting, and if the office decides  
7 to grant the request, the office shall schedule the  
8 second informal resolution meeting. The office shall  
9 give notice to the provider of the time and place of  
10 the second informal resolution meeting. A provider  
11 must have an opportunity to provide additional  
12 information before the second informal resolution  
13 meeting for consideration by the office. A provider's  
14 decision to seek an informal resolution under this  
15 subdivision does not extend the time by which the  
16 provider must request an expedited administrative  
17 hearing under Subdivision (3). The informal  
18 resolution process shall run concurrently with the  
19 administrative hearing process, and the informal  
20 resolution process shall be discontinued once the  
21 State Office of Administrative Hearings issues a final  
22 determination on the payment hold.

23 Revisor's Note

24 (1) Section 531.102(g)(6), Government Code,  
25 refers to the imposition of a payment hold under  
26 Subdivision (2), meaning Section 531.102(g)(2),  
27 Government Code. The provision of Section  
28 531.102(g)(2) related to imposing a payment hold is  
29 revised in this chapter as Section 544.030(a), and the  
30 revised law is drafted accordingly.

31 (2) Section 531.102(g)(6), Government Code,  
32 refers to a payment hold notice provided under "that  
33 subdivision," meaning Section 531.102(g)(2),  
34 Government Code. The provision of Section  
35 531.102(g)(2) related to a payment hold notice is  
36 revised in this chapter as Section 544.0302, and the  
37 revised law is drafted accordingly.

38 (3) Section 531.102(g)(6), Government Code,  
39 refers to the deadline for requesting an expedited  
40 administrative hearing prescribed by Subdivision (3),  
41 meaning Section 531.102(g)(3), Government Code. The  
42 provision of Section 531.102(g)(3) prescribing the  
43 deadline for requesting an expedited administrative  
44 hearing is revised in this chapter as Section  
45 544.0303(a), and the revised law is drafted

1 accordingly.

2 Revised Law

3 Sec. 544.0305. WEBSITE POSTING. The office of inspector  
4 general shall post on the office's publicly available Internet  
5 website a description in plain English of, and a video explaining,  
6 the processes and procedures the office uses to determine whether  
7 to impose a payment hold on a provider under this subchapter. (Gov.  
8 Code, Sec. 531.119.)

9 Source Law

10 Sec. 531.119. WEBSITE POSTING. The  
11 commission's office of inspector general shall post on  
12 its publicly available website a description in plain  
13 English of, and a video explaining, the processes and  
14 procedures the office uses to determine whether to  
15 impose a payment hold on a provider under this  
16 subchapter.

17 Revisor's Note

18 Section 531.119, Government Code, refers to the  
19 processes and procedures the Health and Human Services  
20 Commission's office of inspector general uses in  
21 determining whether to impose a payment hold on a  
22 provider under "this subchapter," meaning Subchapter  
23 C, Chapter 531, Government Code. The provisions of  
24 Subchapter C, Chapter 531, relating to imposing a  
25 payment hold are revised as this subchapter, and the  
26 revised law is drafted accordingly.

27 SUBCHAPTER H. MANAGED CARE ORGANIZATION PREVENTION AND  
28 INVESTIGATION OF FRAUD AND ABUSE

29 Revised Law

30 Sec. 544.0351. APPLICABILITY OF SUBCHAPTER. This  
31 subchapter applies only to a managed care organization that  
32 provides or arranges for the provision of health care services to an  
33 individual under a government-funded program, including Medicaid  
34 and the child health plan program. (Gov. Code, Sec. 531.113(a)  
35 (part).)

36 Source Law

37 Sec. 531.113. MANAGED CARE ORGANIZATIONS:

1 SPECIAL INVESTIGATIVE UNITS OR CONTRACTS. (a) Each  
2 managed care organization that provides or arranges  
3 for the provision of health care services to an  
4 individual under a government-funded program,  
5 including Medicaid and the child health plan program,  
6 . . .

7 Revised Law

8 Sec. 544.0352. SPECIAL INVESTIGATIVE UNIT OR CONTRACTED  
9 ENTITY TO INVESTIGATE FRAUD AND ABUSE. (a) A managed care  
10 organization to which this subchapter applies shall:

11 (1) establish and maintain a special investigative  
12 unit within the organization to investigate fraudulent claims and  
13 other types of program abuse by recipients or enrollees, as  
14 applicable, and service providers; or

15 (2) contract with another entity to investigate  
16 fraudulent claims and other types of program abuse by recipients or  
17 enrollees, as applicable, and service providers.

18 (b) A managed care organization that contracts for the  
19 investigation of fraudulent claims and other types of program abuse  
20 by recipients or enrollees, as applicable, and service providers  
21 under Subsection (a)(2) shall file with the office of inspector  
22 general:

23 (1) a copy of the written contract;

24 (2) the names, addresses, telephone numbers, and fax  
25 numbers of the principals of the entity with which the organization  
26 contracts; and

27 (3) a description of the qualifications of the  
28 principals of the entity with which the organization contracts.

29 (Gov. Code, Secs. 531.113(a) (part), (c).)

30 Source Law

31 (a) [Each managed care organization that  
32 provides or arranges for the provision of health care  
33 services to an individual under a government-funded  
34 program] . . . shall:

35 (1) establish and maintain a special  
36 investigative unit within the managed care  
37 organization to investigate fraudulent claims and  
38 other types of program abuse by recipients and service  
39 providers; or

40 (2) contract with another entity for the  
41 investigation of fraudulent claims and other types of  
42 program abuse by recipients and service providers.

1 (c) If a managed care organization contracts for  
2 the investigation of fraudulent claims and other types  
3 of program abuse by recipients and service providers  
4 under Subsection (a)(2), the managed care organization  
5 shall file with the commission's office of inspector  
6 general:

- 7 (1) a copy of the written contract;  
8 (2) the names, addresses, telephone  
9 numbers, and fax numbers of the principals of the  
10 entity with which the managed care organization has  
11 contracted; and  
12 (3) a description of the qualifications of  
13 the principals of the entity with which the managed  
14 care organization has contracted.

15 Revisor's Note

16 Sections 531.113(a) and (c), Government Code,  
17 refer to "recipients" under government-funded health  
18 care programs, including Medicaid and the child health  
19 plan program. A person who receives benefits under  
20 Medicaid is generally referred to as a "recipient" and  
21 a person who receives benefits under the child health  
22 plan program is generally referred to as an  
23 "enrollee." The revised law substitutes a reference  
24 to "recipients or enrollees, as applicable" for  
25 "recipients" for accuracy and consistency throughout  
26 Subtitle I, Title 4, Government Code, which includes  
27 this chapter.

28 Revised Law

29 Sec. 544.0353. FRAUD AND ABUSE PREVENTION PLAN. (a) A  
30 managed care organization to which this subchapter applies shall:

- 31 (1) adopt a plan to prevent and reduce fraud and abuse;  
32 and  
33 (2) annually file the plan with the office of  
34 inspector general for approval.

35 (b) The plan must include:

- 36 (1) a description of the organization's procedures  
37 for:  
38 (A) detecting and investigating possible acts of  
39 fraud or abuse;  
40 (B) mandatory reporting of possible acts of fraud  
41 or abuse to the office of inspector general; and

1 (C) educating and training personnel to prevent  
2 fraud and abuse;

3 (2) the name, address, telephone number, and fax  
4 number of the individual responsible for carrying out the plan;

5 (3) a description or chart outlining the  
6 organizational arrangement of the organization's personnel  
7 responsible for investigating and reporting possible acts of fraud  
8 or abuse;

9 (4) a detailed description of the results of fraud and  
10 abuse investigations the organization's special investigative unit  
11 or the entity with which the organization contracts under Section  
12 544.0352(a)(2) conducts; and

13 (5) provisions for maintaining the confidentiality of  
14 any patient information relevant to a fraud or abuse investigation.  
15 (Gov. Code, Sec. 531.113(b).)

16 Source Law

17 (b) Each managed care organization subject to  
18 this section shall adopt a plan to prevent and reduce  
19 fraud and abuse and annually file that plan with the  
20 commission's office of inspector general for approval.  
21 The plan must include:

22 (1) a description of the managed care  
23 organization's procedures for detecting and  
24 investigating possible acts of fraud or abuse;

25 (2) a description of the managed care  
26 organization's procedures for the mandatory reporting  
27 of possible acts of fraud or abuse to the commission's  
28 office of inspector general;

29 (3) a description of the managed care  
30 organization's procedures for educating and training  
31 personnel to prevent fraud and abuse;

32 (4) the name, address, telephone number,  
33 and fax number of the individual responsible for  
34 carrying out the plan;

35 (5) a description or chart outlining the  
36 organizational arrangement of the managed care  
37 organization's personnel responsible for  
38 investigating and reporting possible acts of fraud or  
39 abuse;

40 (6) a detailed description of the results  
41 of investigations of fraud and abuse conducted by the  
42 managed care organization's special investigative unit  
43 or the entity with which the managed care organization  
44 contracts under Subsection (a)(2); and

45 (7) provisions for maintaining the  
46 confidentiality of any patient information relevant to  
47 an investigation of fraud or abuse.

48 Revised Law

49 Sec. 544.0354. ASSISTANCE AND OVERSIGHT BY OFFICE OF

1 INSPECTOR GENERAL. (a) The office of inspector general may review  
2 the records of a managed care organization to which this subchapter  
3 applies to determine compliance with this subchapter.

4 (b) The office of inspector general, in consultation with  
5 the commission, shall:

6 (1) investigate, including by means of regular audits,  
7 possible fraud, waste, and abuse by managed care organizations to  
8 which this subchapter applies;

9 (2) establish requirements for providing training to  
10 and regular oversight of special investigative units established by  
11 organizations under Section 544.0352(a)(1) and entities with which  
12 organizations contract under Section 544.0352(a)(2);

13 (3) establish requirements for approving plans to  
14 prevent and reduce fraud and abuse organizations adopt under  
15 Section 544.0353;

16 (4) evaluate statewide Medicaid fraud, waste, and  
17 abuse trends and communicate those trends to special investigative  
18 units and contracted entities to determine the prevalence of those  
19 trends;

20 (5) as needed, assist organizations in discovering or  
21 investigating fraud, waste, and abuse; and

22 (6) provide ongoing, regular training to appropriate  
23 commission and office staff concerning fraud, waste, and abuse in a  
24 managed care setting, including training relating to fraud, waste,  
25 and abuse by service providers, recipients, and enrollees. (Gov.  
26 Code, Secs. 531.113(d), (d-1).)

27 Source Law

28 (d) The commission's office of inspector general  
29 may review the records of a managed care organization  
30 to determine compliance with this section.

31 (d-1) The commission's office of inspector  
32 general, in consultation with the commission, shall:

33 (1) investigate, including by means of  
34 regular audits, possible fraud, waste, and abuse by  
35 managed care organizations subject to this section;

36 (2) establish requirements for the  
37 provision of training to and regular oversight of  
38 special investigative units established by managed  
39 care organizations under Subsection (a)(1) and  
40 entities with which managed care organizations

1 contract under Subsection (a)(2);  
2 (3) establish requirements for approving  
3 plans to prevent and reduce fraud and abuse adopted by  
4 managed care organizations under Subsection (b);  
5 (4) evaluate statewide fraud, waste, and  
6 abuse trends in Medicaid and communicate those trends  
7 to special investigative units and contracted entities  
8 to determine the prevalence of those trends;  
9 (5) assist managed care organizations in  
10 discovering or investigating fraud, waste, and abuse,  
11 as needed; and  
12 (6) provide ongoing, regular training to  
13 appropriate commission and office staff concerning  
14 fraud, waste, and abuse in a managed care setting,  
15 including training relating to fraud, waste, and abuse  
16 by service providers and recipients.

17 Revisor's Note

18 Section 531.113(d-1)(6), Government Code, refers  
19 to fraud, waste, and abuse in a "managed care setting,"  
20 including fraud, waste, and abuse by "recipients." It  
21 is clear from Section 531.113(a), Government Code,  
22 which is revised in relevant part as Section 544.0351  
23 of this chapter, that the "managed care setting" to  
24 which Section 531.113(d-1)(6) refers includes managed  
25 care provided under Medicaid and the child health plan  
26 program. The revised law refers to both "recipients"  
27 and "enrollees" for the reason stated in the revisor's  
28 note to Section 544.0352 of this chapter.

29 Revised Law

30 Sec. 544.0355. RULES. (a) The executive commissioner, in  
31 consultation with the office of inspector general, shall adopt  
32 rules as necessary to accomplish the purposes of this subchapter,  
33 including rules defining the investigative role of the office with  
34 respect to the investigative role of special investigative units  
35 established by managed care organizations under Section  
36 544.0352(a)(1) and entities with which managed care organizations  
37 contract under Section 544.0352(a)(2).

38 (b) The rules must specify the office of inspector general's  
39 role in:

40 (1) reviewing the findings of special investigative  
41 units and contracted entities;

42 (2) investigating cases in which the overpayment

1 amount sought to be recovered exceeds \$100,000; and

2 (3) investigating providers who are enrolled in more  
3 than one managed care organization. (Gov. Code, Sec. 531.113(e).)

4 Source Law

5 (e) The executive commissioner, in consultation  
6 with the office, shall adopt rules as necessary to  
7 accomplish the purposes of this section, including  
8 rules defining the investigative role of the  
9 commission's office of inspector general with respect  
10 to the investigative role of special investigative  
11 units established by managed care organizations under  
12 Subsection (a)(1) and entities with which managed care  
13 organizations contract under Subsection (a)(2). The  
14 rules adopted under this section must specify the  
15 office's role in:

- 16 (1) reviewing the findings of special  
17 investigative units and contracted entities;
- 18 (2) investigating cases in which the  
19 overpayment amount sought to be recovered exceeds  
20 \$100,000; and
- 21 (3) investigating providers who are  
22 enrolled in more than one managed care organization.

23 SUBCHAPTER I. FINANCIAL ASSISTANCE FRAUD

24 Revised Law

25 Sec. 544.0401. DEFINITION. In this subchapter, "financial  
26 assistance" means assistance provided under the financial  
27 assistance program under Chapter 31, Human Resources Code. (Gov.  
28 Code, Sec. 531.114(a) (part).)

29 Source Law

30 (a) . . . financial assistance under Chapter  
31 31, Human Resources Code, or . . . .

32 Revised Law

33 Sec. 544.0402. FALSE OR MISLEADING INFORMATION RELATED TO  
34 FINANCIAL ASSISTANCE ELIGIBILITY. To establish or maintain the  
35 eligibility of an individual and the individual's family for  
36 financial assistance or to increase or prevent a reduction in the  
37 amount of that assistance, an individual may not intentionally:

- 38 (1) make a statement that the individual knows is  
39 false or misleading;
- 40 (2) misrepresent, conceal, or withhold a fact; or
- 41 (3) knowingly misrepresent a statement as being true.

42 (Gov. Code, Sec. 531.114(a) (part).)

1 Source Law

2 Sec. 531.114. FINANCIAL ASSISTANCE FRAUD. (a)  
3 For purposes of establishing or maintaining the  
4 eligibility of a person and the person's family for  
5 financial assistance . . . for purposes of increasing  
6 or preventing a reduction in the amount of that  
7 assistance, a person may not intentionally:

- 8 (1) make a statement that the person knows  
9 is false or misleading;  
10 (2) misrepresent, conceal, or withhold a  
11 fact; or  
12 (3) knowingly misrepresent a statement as  
13 being true.

14 Revised Law

15 Sec. 544.0403. COMMISSION ACTION FOLLOWING DETERMINATION  
16 OF VIOLATION. If after an investigation the commission determines  
17 that an individual violated Section 544.0402, the commission shall:

18 (1) notify the individual of the alleged violation not  
19 later than the 30th day after the date the commission completes the  
20 investigation and provide the individual with an opportunity for a  
21 hearing on the matter; or

22 (2) refer the matter to the appropriate prosecuting  
23 attorney for prosecution. (Gov. Code, Sec. 531.114(b).)

24 Source Law

25 (b) If after an investigation the commission  
26 determines that a person violated Subsection (a), the  
27 commission shall:

28 (1) notify the person of the alleged  
29 violation not later than the 30th day after the date  
30 the commission completes the investigation and provide  
31 the person with an opportunity for a hearing on the  
32 matter; or

33 (2) refer the matter to the appropriate  
34 prosecuting attorney for prosecution.

35 Revised Law

36 Sec. 544.0404. INELIGIBILITY FOR FINANCIAL ASSISTANCE  
37 FOLLOWING VIOLATION; RIGHT TO APPEAL. (a) An individual is not  
38 eligible to receive financial assistance as provided by Subsection  
39 (b) if the individual waives the right to a hearing or a hearing  
40 officer at an administrative hearing held under this subchapter  
41 determines that the individual violated Section 544.0402. An  
42 individual who a hearing officer determines violated Section  
43 544.0402 may appeal that determination by filing a petition in the  
44 district court in the county in which the violation occurred not

1 later than the 30th day after the date the hearing officer makes the  
2 determination.

3 (b) An individual determined under Subsection (a) to have  
4 violated Section 544.0402 is not eligible for financial assistance:

5 (1) before the first anniversary of the date of that  
6 determination if the individual has no previous violations; and

7 (2) permanently if the individual was previously  
8 determined to have committed a violation.

9 (c) An individual who is convicted of a state or federal  
10 offense for conduct described by Section 544.0402 or who is granted  
11 deferred adjudication or placed on community supervision for that  
12 conduct is permanently disqualified from receiving financial  
13 assistance. (Gov. Code, Secs. 531.114(c), (d), (e).)

14 Source Law

15 (c) If a person waives the right to a hearing or  
16 if a hearing officer at an administrative hearing held  
17 under this section determines that a person violated  
18 Subsection (a), the person is ineligible to receive  
19 financial assistance as provided by Subsection (d). A  
20 person who a hearing officer determines violated  
21 Subsection (a) may appeal that determination by filing  
22 a petition in the district court in the county in which  
23 the violation occurred not later than the 30th day  
24 after the date the hearing officer made the  
25 determination.

26 (d) A person determined under Subsection (c) to  
27 have violated Subsection (a) is not eligible for  
28 financial assistance:

29 (1) before the first anniversary of the  
30 date of that determination, if the person has no  
31 previous violations; and

32 (2) permanently, if the person was  
33 previously determined to have committed a violation.

34 (e) If a person is convicted of a state or  
35 federal offense for conduct described by Subsection  
36 (a), or if the person is granted deferred adjudication  
37 or placed on community supervision for that conduct,  
38 the person is permanently disqualified from receiving  
39 financial assistance.

40 Revised Law

41 Sec. 544.0405. HOUSEHOLD ELIGIBILITY FOR FINANCIAL  
42 ASSISTANCE NOT AFFECTED. This subchapter does not affect the  
43 eligibility for financial assistance of any other member of the  
44 household of an individual who is ineligible as a result of Section  
45 544.0404(b) or (c). (Gov. Code, Sec. 531.114(f).)



1 commission determines that a provider filed a claim for services  
2 provided to an individual after the individual's date of death, as  
3 determined by the vital statistics unit death records, the  
4 commission shall refer the case to the office of inspector general  
5 for investigation. (Gov. Code, Sec. 531.106.)

6 Source Law

7 Sec. 531.106. LEARNING, NEURAL NETWORK, OR  
8 OTHER TECHNOLOGY. (a) The commission shall use  
9 learning, neural network, or other technology to  
10 identify and deter fraud in Medicaid throughout this  
11 state.

12 (b) The commission shall contract with a private  
13 or public entity to develop and implement the  
14 technology. The commission may require the entity it  
15 contracts with to install and operate the technology  
16 at locations specified by the commission, including  
17 commission offices.

18 (c) The data used for data processing shall be  
19 maintained as an independent subset for security  
20 purposes.

21 (d) The commission shall require each health and  
22 human services agency that performs any aspect of  
23 Medicaid to participate in the implementation and use  
24 of the technology.

25 (e) The commission shall maintain all  
26 information necessary to apply the technology to  
27 claims data covering a period of at least two years.

28 (f) The commission shall refer cases identified  
29 by the technology to the commission's office of  
30 inspector general or the office of the attorney  
31 general, as appropriate.

32 (g) Each month, the technology implemented  
33 under this section must match vital statistics unit  
34 death records with Medicaid claims filed by a  
35 provider. If the commission determines that a  
36 provider has filed a claim for services provided to a  
37 person after the person's date of death, as determined  
38 by the vital statistics unit death records, the  
39 commission shall refer the case for investigation to  
40 the commission's office of inspector general.

41 Revised Law

42 Sec. 544.0452. MEDICAID FRAUD INVESTIGATION TRACKING  
43 SYSTEM. (a) The commission shall use an automated fraud  
44 investigation tracking system through the office of inspector  
45 general to monitor the progress of an investigation of suspected  
46 fraud, abuse, or insufficient quality of care in Medicaid.

47 (b) For each case of suspected fraud, abuse, or insufficient  
48 quality of care the technology required under Section 544.0451  
49 identifies, the automated fraud investigation tracking system  
50 must:

1 (1) receive from the technology electronically  
2 transferred records relating to the case;

3 (2) record the details and monitor the status of an  
4 investigation of the case, including maintaining a record of the  
5 beginning and completion dates for each phase of the case  
6 investigation;

7 (3) generate documents and reports related to the  
8 status of the case investigation; and

9 (4) generate standard letters to a provider regarding  
10 the status or outcome of an investigation.

11 (c) The commission shall require each health and human  
12 services agency that performs any part of Medicaid to participate  
13 in implementing and using the automated fraud investigation  
14 tracking system. (Gov. Code, Sec. 531.1061.)

15 Source Law

16 Sec. 531.1061. FRAUD INVESTIGATION TRACKING  
17 SYSTEM. (a) The commission shall use an automated  
18 fraud investigation tracking system through the  
19 commission's office of inspector general to monitor  
20 the progress of an investigation of suspected fraud,  
21 abuse, or insufficient quality of care under Medicaid.

22 (b) For each case of suspected fraud, abuse, or  
23 insufficient quality of care identified by the  
24 technology required under Section 531.106, the  
25 automated fraud investigation tracking system must:

26 (1) receive electronically transferred  
27 records relating to the identified case from the  
28 technology;

29 (2) record the details and monitor the  
30 status of an investigation of the identified case,  
31 including maintaining a record of the beginning and  
32 completion dates for each phase of the case  
33 investigation;

34 (3) generate documents and reports related  
35 to the status of the case investigation; and

36 (4) generate standard letters to a  
37 provider regarding the status or outcome of an  
38 investigation.

39 (c) The commission shall require each health and  
40 human services agency that performs any aspect of  
41 Medicaid to participate in the implementation and use  
42 of the automated fraud investigation tracking system.

43 Revised Law

44 Sec. 544.0453. MEDICAID FRAUD DETECTION TECHNOLOGY. The  
45 commission may contract with a contractor who specializes in  
46 developing technology capable of identifying fraud patterns  
47 exhibited by Medicaid recipients to:

1 (1) develop and implement the fraud detection  
2 technology; and

3 (2) determine whether a fraud pattern by Medicaid  
4 recipients is present in the recipients' eligibility files the  
5 commission maintains. (Gov. Code, Sec. 531.111.)

6 Source Law

7 Sec. 531.111. FRAUD DETECTION TECHNOLOGY. The  
8 commission may contract with a contractor who  
9 specializes in developing technology capable of  
10 identifying patterns of fraud exhibited by Medicaid  
11 recipients to:

12 (1) develop and implement the fraud  
13 detection technology; and

14 (2) determine if a pattern of fraud by  
15 Medicaid recipients is present in the recipients'  
16 eligibility files maintained by the commission.

17 Revised Law

18 Sec. 544.0454. DATA MATCHING AGAINST FEDERAL FELON LIST.  
19 The commission shall develop and implement a system to  
20 cross-reference the list of fugitive felons the federal government  
21 maintains with data collected for the following programs:

22 (1) the child health plan program;

23 (2) the financial assistance program under Chapter 31,  
24 Human Resources Code;

25 (3) Medicaid;

26 (4) nutritional assistance programs under Chapter 33,  
27 Human Resources Code;

28 (5) long-term care services, as defined by Section  
29 22.0011, Human Resources Code;

30 (6) community-based support services identified or  
31 provided in accordance with Section \_\_\_\_\_ [[[Section 531.02481]]];  
32 and

33 (7) other health and human services programs, as  
34 appropriate. (Gov. Code, Sec. 531.115.)

35 Source Law

36 Sec. 531.115. FEDERAL FELONY MATCH. The  
37 commission shall develop and implement a system to  
38 cross-reference data collected for the programs listed  
39 under Section 531.008(c) with the list of fugitive  
40 felons maintained by the federal government.

1 Revisor's Note

2 Section 531.115, Government Code, refers to "the  
3 programs listed under Section 531.008(c)," Government  
4 Code. Before the enactment of Chapter 837 (S.B. 200),  
5 Acts of the 84th Legislature, Regular Session, 2015,  
6 Section 531.008(c) required the establishment within  
7 the Health and Human Services Commission of a division  
8 to make eligibility determinations for listed health  
9 and human services programs. Section 1.09 of Chapter  
10 837 amended Section 531.008(c) and repealed that list  
11 of programs. Because the remaining reference to "the  
12 programs listed under Section 531.008(c)" in Section  
13 531.115 is an oversight, the revised law substitutes  
14 for the quoted language the health and human services  
15 programs that were listed in Section 531.008(c) before  
16 the subsection was amended.

17 Revised Law

18 Sec. 544.0455. ELECTRONIC DATA MATCHING. (a) In this  
19 section, "public assistance program" includes:

- 20 (1) Medicaid;
- 21 (2) the financial assistance program under Chapter 31,  
22 Human Resources Code; and
- 23 (3) a nutritional assistance program under Chapter 33,  
24 Human Resources Code, including the supplemental nutrition  
25 assistance program under that chapter.

26 (b) At least quarterly, the commission shall conduct  
27 electronic data matches for a recipient of public assistance  
28 program benefits to verify the identity, income, employment status,  
29 and other factors that affect the recipient's eligibility. To  
30 verify a recipient's eligibility, the electronic data matching must  
31 match information the recipient provided with information  
32 contained in databases appropriate federal and state agencies  
33 maintain.

34 (c) Health and human services agencies shall cooperate with

1 the commission by providing data or any other assistance necessary  
2 to conduct the electronic data matches required by this section.

3 (d) The commission shall enter into a memorandum of  
4 understanding with each state agency from which data is required to  
5 conduct electronic data matches under this section and Section  
6 544.0456.

7 (e) The commission may contract with a public or private  
8 entity to conduct the electronic data matches required by this  
9 section.

10 (f) The executive commissioner shall establish procedures  
11 by which the commission or a health and human services agency the  
12 commission designates verifies the electronic data matches the  
13 commission conducts under this section. Not later than the 20th day  
14 after the date an electronic data match is verified, the commission  
15 shall remove from eligibility a recipient who is determined to be  
16 ineligible for a public assistance program. (Gov. Code, Sec.  
17 531.110.)

18 Source Law

19 Sec. 531.110. ELECTRONIC DATA MATCHING PROGRAM.

20 (a) In this section, "public assistance program"  
21 includes:

- 22 (1) Medicaid;  
23 (2) the financial assistance program under  
24 Chapter 31, Human Resources Code; and  
25 (3) a nutritional assistance program under  
26 Chapter 33, Human Resources Code, including the  
27 supplemental nutrition assistance program under that  
28 chapter.

29 (a-1) The commission shall conduct electronic  
30 data matches for a recipient of benefits under a public  
31 assistance program at least quarterly to verify the  
32 identity, income, employment status, and other factors  
33 that affect the eligibility of the recipient.

34 (b) To verify eligibility of a recipient of  
35 public assistance program benefits, the electronic  
36 data matching must match information provided by the  
37 recipient with information contained in databases  
38 maintained by appropriate federal and state agencies.

39 (c) The health and human services agencies shall  
40 cooperate with the commission by providing data or any  
41 other assistance necessary to conduct the electronic  
42 data matches required by this section.

43 (c-1) The commission shall enter into a  
44 memorandum of understanding with each state agency  
45 from which data is required to conduct electronic data  
46 matches under this section and Section 531.1081.

47 (d) The commission may contract with a public or  
48 private entity to conduct the electronic data matches  
49 required by this section.

1 (e) The executive commissioner shall establish  
2 procedures by which the commission, or a health and  
3 human services agency designated by the commission,  
4 verifies the electronic data matches conducted by the  
5 commission under this section. Not later than the  
6 20th day after the date the electronic data match is  
7 verified, the commission shall remove from eligibility  
8 a recipient who is determined to be ineligible for a  
9 public assistance program.

10 Revised Law

11 Sec. 544.0456. METHODS TO REDUCE FRAUD, WASTE, AND ABUSE IN  
12 CERTAIN PUBLIC ASSISTANCE PROGRAMS. (a) In this section:

13 (1) "Financial assistance benefits" means monetary  
14 payments under:

15 (A) the federal Temporary Assistance for Needy  
16 Families program operated under Chapter 31, Human Resources Code;  
17 or

18 (B) this state's temporary assistance and  
19 support services program operated under Chapter 34, Human Resources  
20 Code.

21 (2) "Supplemental nutrition assistance benefits"  
22 means monetary payments under the supplemental nutrition  
23 assistance program operated under Chapter 33, Human Resources Code.

24 (b) To the extent not otherwise provided by this subtitle or  
25 Title 2, Human Resources Code, and in accordance with this section,  
26 the commission shall develop and implement methods for reducing  
27 fraud, waste, and abuse in public assistance programs.

28 (c) On a monthly basis, the commission shall:

29 (1) conduct electronic data matches with the Texas  
30 Lottery Commission to determine whether a recipient of supplemental  
31 nutrition assistance benefits or a recipient's household member  
32 received reportable lottery winnings;

33 (2) use the database system developed under Section  
34 \_\_\_\_\_ [[[Section 531.0214]]] to:

35 (A) match vital statistics unit death records  
36 with a list of individuals eligible for financial assistance or  
37 supplemental nutrition assistance benefits; and

38 (B) ensure that any individual receiving

1 assistance under either program who is discovered to be deceased  
2 has the individual's eligibility for assistance promptly  
3 terminated; and

4 (3) review the out-of-state electronic benefit  
5 transfer card transactions a recipient of supplemental nutrition  
6 assistance benefits made to determine whether those transactions  
7 indicate a possible change in the recipient's residence.

8 (d) The commission shall immediately review a recipient's  
9 eligibility for public assistance benefits if the commission  
10 discovers information under this section that affects the  
11 recipient's eligibility.

12 (e) A recipient presumptively commits a program violation  
13 if the recipient fails to disclose lottery winnings that are  
14 required to be reported to the commission under a public assistance  
15 program.

16 (f) The executive commissioner shall adopt rules necessary  
17 to implement this section. (Gov. Code, Sec. 531.1081.)

18 Source Law

19 Sec. 531.1081. INTEGRITY OF CERTAIN PUBLIC  
20 ASSISTANCE PROGRAMS. (a) In this section:

21 (1) "Financial assistance benefits" means  
22 money payments under the federal Temporary Assistance  
23 for Needy Families program operated under Chapter 31,  
24 Human Resources Code, or under the state temporary  
25 assistance and support services program operated under  
26 Chapter 34, Human Resources Code.

27 (2) "Supplemental nutrition assistance  
28 benefits" means money payments under the supplemental  
29 nutrition assistance program operated under Chapter  
30 33, Human Resources Code.

31 (b) To the extent not otherwise provided by this  
32 subtitle or Title 2, Human Resources Code, the  
33 commission shall develop and implement, in accordance  
34 with this section, methods for reducing abuse, fraud,  
35 and waste in public assistance programs.

36 (c) On a monthly basis, the commission shall:

37 (1) conduct electronic data matches with  
38 the Texas Lottery Commission to determine if a  
39 recipient of supplemental nutrition assistance  
40 benefits or a recipient's household member received  
41 reportable lottery winnings;

42 (2) use the database system developed  
43 under Section 531.0214 to match vital statistics unit  
44 death records with a list of individuals eligible for  
45 financial assistance or supplemental nutrition  
46 assistance benefits, and ensure that any individual  
47 receiving assistance under either program who is  
48 discovered deceased has their eligibility for  
49 assistance promptly terminated; and

1 (3) review the out-of-state electronic  
2 benefit transfer card transactions made by a recipient  
3 of supplemental nutrition assistance benefits to  
4 determine whether those transactions indicate a  
5 possible change in the recipient's residence.

6 (d) The commission shall immediately review the  
7 eligibility of a recipient of public assistance  
8 benefits if the commission discovers information under  
9 this section that affects the recipient's eligibility.

10 (e) A recipient who fails to disclose lottery  
11 winnings that are required to be reported to the  
12 commission under a public assistance program  
13 presumptively commits a program violation.

14 (f) The executive commissioner shall adopt  
15 rules necessary to implement this section.

16 Revisor's Note  
17 (End of Subchapter)

18 Section 531.1112, Government Code, requires the  
19 Health and Human Services Commission and the  
20 commission's office of inspector general to study the  
21 feasibility of increasing the use of technology to  
22 strengthen the detection and deterrence of Medicaid  
23 fraud and to implement any methods the commission and  
24 office determine are effective. Section 6(b), Chapter  
25 268 (S.B. 10), Acts of the 80th Legislature, Regular  
26 Session, 2007, requires the commission to submit to  
27 the legislature not later than December 1, 2008, a  
28 report detailing the findings of the study, which must  
29 include a description of any method described by  
30 Section 531.1112(b) that the commission has  
31 implemented or intends to implement. The commission  
32 conducted the study and, in December 2008, submitted  
33 the required report to the legislature. Therefore,  
34 the revised law omits the provision as executed. The  
35 omitted law reads:

36 Sec. 531.1112. STUDY CONCERNING  
37 INCREASED USE OF TECHNOLOGY TO STRENGTHEN  
38 FRAUD DETECTION AND DETERRENCE;  
39 IMPLEMENTATION. (a) The commission and the  
40 commission's office of inspector general  
41 shall jointly study the feasibility of  
42 increasing the use of technology to  
43 strengthen the detection and deterrence of  
44 fraud in Medicaid. The study must include  
45 the determination of the feasibility of  
46 using technology to verify a person's  
47 citizenship and eligibility for coverage.

48 (b) The commission shall implement

1 any methods the commission and the  
2 commission's office of inspector general  
3 determine are effective at strengthening  
4 fraud detection and deterrence.

5 SUBCHAPTER K. RECOVERY AND RECOUPMENT IN CASES OF FRAUD, ABUSE, AND  
6 OVERCHARGES

7 Revised Law

8 Sec. 544.0501. RECOVERY MONITORING SYSTEM. (a) The  
9 commission shall use an automated recovery monitoring system to  
10 monitor the collections process for a settled case of fraud, abuse,  
11 or insufficient quality of care in Medicaid.

12 (b) The recovery monitoring system must:

13 (1) monitor the collection of money resulting from  
14 settled cases, including by recording:

15 (A) monetary payments received from a provider  
16 who agreed to a monetary payment plan; and

17 (B) deductions taken through the recoupment  
18 program from subsequent Medicaid claims the provider filed; and

19 (2) provide immediate notice of a provider who:

20 (A) agreed to a monetary payment plan or to  
21 deductions through the recoupment program from subsequent Medicaid  
22 claims; and

23 (B) fails to comply with the settlement  
24 agreement, including by providing notice of a provider who:

25 (i) does not make a scheduled payment; or

26 (ii) pays less than a scheduled amount.

27 (Gov. Code, Sec. 531.1062.)

28 Source Law

29 Sec. 531.1062. RECOVERY MONITORING SYSTEM. (a)  
30 The commission shall use an automated recovery  
31 monitoring system to monitor the collections process  
32 for a settled case of fraud, abuse, or insufficient  
33 quality of care under Medicaid.

34 (b) The recovery monitoring system must:

35 (1) monitor the collection of funds  
36 resulting from settled cases, including:

37 (A) recording monetary payments  
38 received from a provider who has agreed to a monetary  
39 payment plan; and

40 (B) recording deductions taken  
41 through the recoupment program from subsequent  
42 Medicaid claims filed by the provider; and

43 (2) provide immediate notice of a provider

1 who has agreed to a monetary payment plan or to  
2 deductions through the recoupment program from  
3 subsequent Medicaid claims who fails to comply with  
4 the settlement agreement, including providing notice  
5 of a provider who does not make a scheduled payment or  
6 who pays less than the scheduled amount.

7 Revised Law

8 Sec. 544.0502. PAYMENT RECOVERY EFFORTS BY CERTAIN PERSONS;  
9 RETENTION OF RECOVERED AMOUNTS. (a) In this section, "contracted  
10 entity" means an entity with which a managed care organization  
11 contracts under Section 544.0352(a)(2).

12 (b) A managed care organization or the organization's  
13 contracted entity that discovers Medicaid or child health plan  
14 program fraud or abuse shall:

15 (1) immediately submit written notice to the office of  
16 inspector general and the office of the attorney general that:

17 (A) is in the form and manner the office of  
18 inspector general prescribes; and

19 (B) contains a detailed description of:

20 (i) the fraud or abuse; and

21 (ii) each payment made to a provider as a  
22 result of the fraud or abuse;

23 (2) subject to Subsection (c), begin payment recovery  
24 efforts; and

25 (3) ensure that any payment recovery efforts in which  
26 the organization engages are in accordance with rules the executive  
27 commissioner adopts.

28 (c) A managed care organization or the organization's  
29 contracted entity may not engage in payment recovery efforts if:

30 (1) the amount sought to be recovered under Subsection  
31 (b)(2) exceeds \$100,000; and

32 (2) not later than the 10th business day after the date  
33 the organization or entity notifies the office of inspector general  
34 and the office of the attorney general under Subsection (b)(1), the  
35 organization or entity receives a notice from either office  
36 indicating that the organization or entity is not authorized to  
37 proceed with recovery efforts.

1 (d) A managed care organization may retain one-half of any  
2 money the organization or the organization's contracted entity  
3 recovers under Subsection (b)(2). The organization shall remit the  
4 remaining amount of recovered money to the office of inspector  
5 general for deposit to the credit of the general revenue fund.

6 (e) If the office of inspector general notifies a managed  
7 care organization in accordance with Subsection (c), proceeds with  
8 recovery efforts, and recovers all or part of the payments the  
9 organization identified as required by Subsection (b)(1), the  
10 organization is entitled to one-half of the amount recovered for  
11 each payment the organization identified after any federal share is  
12 deducted. The organization may not receive more than one-half of  
13 the total amount recovered after any federal share is deducted.

14 (f) Notwithstanding this section, if the office of  
15 inspector general discovers Medicaid or child health plan program  
16 fraud, waste, or abuse in performing the office's duties, the  
17 office may recover payments made to a provider as a result of the  
18 fraud, waste, or abuse as otherwise provided by this chapter. The  
19 office shall deposit all payments the office recovers under this  
20 subsection to the credit of the general revenue fund.

21 (g) The office of inspector general shall coordinate with  
22 appropriate managed care organizations to ensure that the office  
23 and an organization or an organization's contracted entity do not  
24 both begin payment recovery efforts under this section for the same  
25 case of fraud, waste, or abuse.

26 (h) A managed care organization shall submit a quarterly  
27 report to the office of inspector general detailing the amount of  
28 money the organization recovered under Subsection (b)(2).

29 (i) The executive commissioner shall adopt rules necessary  
30 to implement this section, including rules establishing due process  
31 procedures that a managed care organization must follow when  
32 engaging in payment recovery efforts as provided by this section.  
33 In adopting the rules establishing due process procedures, the  
34 executive commissioner shall require that a managed care

1 organization or an organization's contracted entity that engages in  
2 payment recovery efforts as provided by this section and Section  
3 544.0503 provide to a provider required to use electronic visit  
4 verification:

5 (1) written notice of the organization's intent to  
6 recoup overpayments in accordance with Section 544.0503; and

7 (2) at least 60 days to cure any defect in a claim  
8 before the organization may begin efforts to collect overpayments.

9 (Gov. Code, Sec. 531.1131.)

10 Source Law

11 Sec. 531.1131. FRAUD AND ABUSE RECOVERY BY  
12 CERTAIN PERSONS; RETENTION OF RECOVERED AMOUNTS. (a)  
13 If a managed care organization or an entity with which  
14 the managed care organization contracts under Section  
15 531.113(a)(2) discovers fraud or abuse in Medicaid or  
16 the child health plan program, the organization or  
17 entity shall:

18 (1) immediately submit written notice to  
19 the commission's office of inspector general and the  
20 office of the attorney general in the form and manner  
21 prescribed by the office of inspector general and  
22 containing a detailed description of the fraud or  
23 abuse and each payment made to a provider as a result  
24 of the fraud or abuse;

25 (2) subject to Subsection (b), begin  
26 payment recovery efforts; and

27 (3) ensure that any payment recovery  
28 efforts in which the organization engages are in  
29 accordance with applicable rules adopted by the  
30 executive commissioner.

31 (b) If the amount sought to be recovered under  
32 Subsection (a)(2) exceeds \$100,000, the managed care  
33 organization or the contracted entity described by  
34 Subsection (a) may not engage in payment recovery  
35 efforts if, not later than the 10th business day after  
36 the date the organization or entity notified the  
37 commission's office of inspector general and the  
38 office of the attorney general under Subsection  
39 (a)(1), the organization or entity receives a notice  
40 from either office indicating that the organization or  
41 entity is not authorized to proceed with recovery  
42 efforts.

43 (c) A managed care organization may retain  
44 one-half of any money recovered under Subsection  
45 (a)(2) by the organization or the contracted entity  
46 described by Subsection (a). The managed care  
47 organization shall remit the remaining amount of money  
48 recovered under Subsection (a)(2) to the commission's  
49 office of inspector general for deposit to the credit  
50 of the general revenue fund.

51 (c-1) If the commission's office of inspector  
52 general notifies a managed care organization under  
53 Subsection (b), proceeds with recovery efforts, and  
54 recovers all or part of the payments the organization  
55 identified as required by Subsection (a)(1), the  
56 organization is entitled to one-half of the amount  
57 recovered for each payment the organization identified

1 after any applicable federal share is deducted. The  
2 organization may not receive more than one-half of the  
3 total amount of money recovered after any applicable  
4 federal share is deducted.

5 (c-2) Notwithstanding any provision of this  
6 section, if the commission's office of inspector  
7 general discovers fraud, waste, or abuse in Medicaid  
8 or the child health plan program in the performance of  
9 its duties, the office may recover payments made to a  
10 provider as a result of the fraud, waste, or abuse as  
11 otherwise provided by this subchapter. All payments  
12 recovered by the office under this subsection shall be  
13 deposited to the credit of the general revenue fund.

14 (c-3) The commission's office of inspector  
15 general shall coordinate with appropriate managed care  
16 organizations to ensure that the office and an  
17 organization or an entity with which an organization  
18 contracts under Section 531.113(a)(2) do not both  
19 begin payment recovery efforts under this section for  
20 the same case of fraud, waste, or abuse.

21 (d) A managed care organization shall submit a  
22 quarterly report to the commission's office of  
23 inspector general detailing the amount of money  
24 recovered under Subsection (a)(2).

25 (e) The executive commissioner shall adopt  
26 rules necessary to implement this section, including  
27 rules establishing due process procedures that must be  
28 followed by managed care organizations when engaging  
29 in payment recovery efforts as provided by this  
30 section.

31 (f) In adopting rules establishing due process  
32 procedures under Subsection (e), the executive  
33 commissioner shall require that a managed care  
34 organization or an entity with which the managed care  
35 organization contracts under Section 531.113(a)(2)  
36 that engages in payment recovery efforts in accordance  
37 with this section and Section 531.1135 provide:

38 (1) written notice to a provider required  
39 to use electronic visit verification of the  
40 organization's intent to recoup overpayments in  
41 accordance with Section 531.1135; and

42 (2) a provider described by Subdivision  
43 (1) at least 60 days to cure any defect in a claim  
44 before the organization may begin any efforts to  
45 collect overpayments.

#### 46 Revisor's Note

47 Section 531.1131(c-2), Government Code,  
48 authorizes the Health and Human Services Commission's  
49 office of inspector general to recover payments made  
50 to a provider as a result of fraud, waste, or abuse as  
51 otherwise provided by this "subchapter," meaning  
52 Subchapter C, Chapter 531, Government Code. Although  
53 the law revised in this chapter includes provisions  
54 not included in Subchapter C, Chapter 531, the revised  
55 law substitutes "chapter" for "subchapter" because the  
56 law revised in this chapter is substantially derived

1 from Subchapter C, Chapter 531, and the inclusion of  
2 provisions not derived from Subchapter C does not  
3 expand the scope of the office's authority to recover  
4 payments.

5 Revised Law

6 Sec. 544.0503. PROCESS FOR MANAGED CARE ORGANIZATIONS TO  
7 RECOUP OVERPAYMENTS RELATED TO ELECTRONIC VISIT VERIFICATION  
8 TRANSACTIONS. (a) The executive commissioner shall adopt rules  
9 that standardize the process by which a managed care organization  
10 collects alleged overpayments that are made to a health care  
11 provider and discovered through an audit or investigation the  
12 organization conducts secondary to missing electronic visit  
13 verification information. The rules must require that the  
14 organization:

15 (1) provide written notice to a provider:

16 (A) of the organization's intent to recoup  
17 overpayments not later than the 30th day after the date an audit is  
18 complete;

19 (B) of the specific claims and electronic visit  
20 verification transactions that are the basis of the overpayment;

21 (C) of the process the provider should use to  
22 communicate with the organization to provide information about the  
23 electronic visit verification transactions;

24 (D) of the provider's option to seek an informal  
25 resolution of the alleged overpayment;

26 (E) of the process to appeal the determination  
27 that an overpayment was made; and

28 (F) if the provider intends to respond to the  
29 notice, that the provider must respond not later than the 30th day  
30 after the date the provider receives the notice; and

31 (2) limit the duration of audits to 24 months.

32 (b) Notwithstanding any other law, a managed care  
33 organization may not attempt to recover an overpayment described by  
34 Subsection (a) until the provider exhausts all rights to an appeal.

1 (Gov. Code, Sec. 531.1135.)

2 Source Law

3 Sec. 531.1135. MANAGED CARE ORGANIZATIONS:  
4 PROCESS TO RECOUP CERTAIN OVERPAYMENTS. (a) The  
5 executive commissioner shall adopt rules that  
6 standardize the process by which a managed care  
7 organization collects alleged overpayments that are  
8 made to a health care provider and discovered through  
9 an audit or investigation conducted by the  
10 organization secondary to missing electronic visit  
11 verification information. In adopting rules under  
12 this section, the executive commissioner shall require  
13 that the managed care organization:

14 (1) provide written notice of the  
15 organization's intent to recoup overpayments not later  
16 than the 30th day after the date an audit is complete;  
17 and

18 (2) limit the duration of audits to 24  
19 months.

20 (b) The executive commissioner shall require  
21 that the notice required under this section inform the  
22 provider:

23 (1) of the specific claims and electronic  
24 visit verification transactions that are the basis of  
25 the overpayment;

26 (2) of the process the provider should use  
27 to communicate with the managed care organization to  
28 provide information about the electronic visit  
29 verification transactions;

30 (3) of the provider's option to seek an  
31 informal resolution of the alleged overpayment;

32 (4) of the process to appeal the  
33 determination that an overpayment was made; and

34 (5) if the provider intends to respond to  
35 the notice, that the provider must respond not later  
36 than the 30th day after the date the provider receives  
37 the notice.

38 (c) Notwithstanding any other law, a managed  
39 care organization may not attempt to recover an  
40 overpayment described by Subsection (a) until the  
41 provider has exhausted all rights to an appeal.

42 Revised Law

43 Sec. 544.0504. RECOVERY AUDIT CONTRACTORS. To the extent  
44 required under Section 1902(a)(42), Social Security Act (42 U.S.C.  
45 Section 1396a(a)(42)), the commission shall establish a program  
46 under which the commission contracts with one or more recovery  
47 audit contractors to identify Medicaid underpayments and  
48 overpayments and recover the overpayments. (Gov. Code, Sec.  
49 531.117.)

50 Source Law

51 Sec. 531.117. RECOVERY AUDIT CONTRACTORS. To  
52 the extent required under Section 1902(a)(42), Social  
53 Security Act (42 U.S.C. Section 1396a(a)(42)), the  
54 commission shall establish a program under which the  
55 commission contracts with one or more recovery audit

1 contractors for purposes of identifying underpayments  
2 and overpayments under Medicaid and recovering the  
3 overpayments.

4 Revised Law

5 Sec. 544.0505. ANNUAL REPORT ON CERTAIN FRAUD AND ABUSE  
6 RECOVERIES. Not later than December 1 of each year, the commission  
7 shall prepare and submit to the legislature a report on the amount  
8 of money recovered during the preceding 12-month period as a result  
9 of investigations and recovery efforts made under Subchapter H and  
10 Section 544.0502 by special investigative units or entities with  
11 which a managed care organization contracts under Section  
12 544.0352(a)(2). The report must specify the amount of money each  
13 managed care organization retained under Section 544.0502(d).  
14 (Gov. Code, Sec. 531.1132.)

15 Source Law

16 Sec. 531.1132. ANNUAL REPORT ON CERTAIN FRAUD  
17 AND ABUSE RECOVERIES. Not later than December 1 of  
18 each year, the commission shall prepare and submit a  
19 report to the legislature relating to the amount of  
20 money recovered during the preceding 12-month period  
21 as a result of investigations and recovery efforts  
22 made under Sections 531.113 and 531.1131 by special  
23 investigative units or entities with which a managed  
24 care organization contracts under Section  
25 531.113(a)(2). The report must specify the amount of  
26 money retained by each managed care organization under  
27 Section 531.1131(c).

28 Revised Law

29 Sec. 544.0506. NOTICE AND INFORMAL RESOLUTION OF PROPOSED  
30 RECOUPMENT OF OVERPAYMENT OR DEBT. (a) The commission or the  
31 office of inspector general shall provide a provider with written  
32 notice of any proposed recoupment of an overpayment or debt and any  
33 damages or penalties relating to a proposed recoupment of an  
34 overpayment or debt arising out of a fraud or abuse investigation.  
35 The notice must include:

- 36 (1) the specific basis for the overpayment or debt;  
37 (2) a description of facts and supporting evidence;  
38 (3) a representative sample of any documents that form  
39 the basis for the overpayment or debt;  
40 (4) the extrapolation methodology;  
41 (5) information relating to the extrapolation

1 methodology used as part of the investigation and the methods used  
2 to determine the overpayment or debt in sufficient detail so that  
3 the extrapolation results may be demonstrated to be statistically  
4 valid and are fully reproducible;

5 (6) the calculation of the overpayment or debt amount;

6 (7) the amount of damages and penalties, if  
7 applicable; and

8 (8) a description of administrative and judicial due  
9 process remedies, including the provider's option to seek informal  
10 resolution, the provider's right to seek a formal administrative  
11 appeal hearing, or that the provider may seek both.

12 (b) A provider may request an informal resolution meeting.  
13 On receipt of the request, the office of inspector general shall  
14 schedule the meeting and give notice to the provider of the time and  
15 place of the meeting. The informal resolution process shall run  
16 concurrently with the administrative hearing process, and the  
17 administrative hearing process may not be delayed on account of the  
18 informal resolution process.

19 (c) The commission shall provide the notice required by  
20 Subsection (a) to a provider that is a hospital not later than the  
21 90th day before the date the overpayment or debt that is the subject  
22 of the notice must be paid. (Gov. Code, Sec. 531.120.)

23 Source Law

24 Sec. 531.120. NOTICE AND INFORMAL RESOLUTION OF  
25 PROPOSED RECOUPMENT OF OVERPAYMENT OR DEBT. (a) The  
26 commission or the commission's office of inspector  
27 general shall provide a provider with written notice  
28 of any proposed recoupment of an overpayment or debt  
29 and any damages or penalties relating to a proposed  
30 recoupment of an overpayment or debt arising out of a  
31 fraud or abuse investigation. The notice must  
32 include:

33 (1) the specific basis for the overpayment  
34 or debt;

35 (2) a description of facts and supporting  
36 evidence;

37 (3) a representative sample of any  
38 documents that form the basis for the overpayment or  
39 debt;

40 (4) the extrapolation methodology;

41 (4-a) information relating to the  
42 extrapolation methodology used as part of the  
43 investigation and the methods used to determine the  
44 overpayment or debt in sufficient detail so that the

1 extrapolation results may be demonstrated to be  
2 statistically valid and are fully reproducible;

3 (5) the calculation of the overpayment or  
4 debt amount;

5 (6) the amount of damages and penalties,  
6 if applicable; and

7 (7) a description of administrative and  
8 judicial due process remedies, including the  
9 provider's option to seek informal resolution, the  
10 provider's right to seek a formal administrative  
11 appeal hearing, or that the provider may seek both.

12 (b) A provider may request an informal  
13 resolution meeting under this section, and on receipt  
14 of the request, the office shall schedule the informal  
15 resolution meeting. The office shall give notice to  
16 the provider of the time and place of the informal  
17 resolution meeting. The informal resolution process  
18 shall run concurrently with the administrative hearing  
19 process, and the administrative hearing process may  
20 not be delayed on account of the informal resolution  
21 process.

22 (c) The commission shall provide the notice  
23 required by Subsection (a) to a provider that is a  
24 hospital not later than the 90th day before the date  
25 the overpayment or debt that is the subject of the  
26 notice must be paid.

27 Revised Law

28 Sec. 544.0507. APPEAL OF DETERMINATION TO RECOUP  
29 OVERPAYMENT OR DEBT. (a) A provider must request an appeal under  
30 this section not later than the 30th day after the date the provider  
31 is notified that the commission or the office of inspector general  
32 will seek to recover an overpayment or debt from the provider.

33 (b) On receipt of a timely written request by a provider who  
34 is the subject of a recoupment of overpayment or debt arising out of  
35 a fraud or abuse investigation, the office of inspector general  
36 shall file a docketing request with the State Office of  
37 Administrative Hearings or the commission's appeals division, as  
38 the provider requests, for an administrative hearing regarding the  
39 proposed recoupment amount and any associated damages or penalties.  
40 The office shall file the docketing request not later than the 60th  
41 day after the date of the provider's request or not later than the  
42 60th day after completing the informal resolution process, if  
43 applicable.

44 (c) The office of inspector general is responsible for the  
45 costs of an administrative hearing, but a provider is responsible  
46 for the provider's own costs incurred in preparing for the hearing.

47 (d) A provider who is the subject of a recoupment of

1 overpayment or debt arising out of a fraud or abuse investigation  
2 may appeal a final administrative order issued after an  
3 administrative hearing by filing a petition for judicial review in  
4 a district court in Travis County. (Gov. Code, Sec. 531.1201.)

5 Source Law

6 Sec. 531.1201. APPEAL OF DETERMINATION TO  
7 RECOUP OVERPAYMENT OR DEBT. (a) A provider must  
8 request an appeal under this section not later than the  
9 30th day after the date the provider is notified that  
10 the commission or the commission's office of inspector  
11 general will seek to recover an overpayment or debt  
12 from the provider. On receipt of a timely written  
13 request by a provider who is the subject of a  
14 recoupment of overpayment or recoupment of debt  
15 arising out of a fraud or abuse investigation, the  
16 office of inspector general shall file a docketing  
17 request with the State Office of Administrative  
18 Hearings or the Health and Human Services Commission  
19 appeals division, as requested by the provider, for an  
20 administrative hearing regarding the proposed  
21 recoupment amount and any associated damages or  
22 penalties. The office shall file the docketing  
23 request under this section not later than the 60th day  
24 after the date of the provider's request for an  
25 administrative hearing or not later than the 60th day  
26 after the completion of the informal resolution  
27 process, if applicable.

28 (b) The commission's office of inspector general  
29 is responsible for the costs of an administrative  
30 hearing held under Subsection (a), but a provider is  
31 responsible for the provider's own costs incurred in  
32 preparing for the hearing.

33 (d) Following an administrative hearing under  
34 Subsection (a), a provider who is the subject of a  
35 recoupment of overpayment or recoupment of debt  
36 arising out of a fraud or abuse investigation may  
37 appeal a final administrative order by filing a  
38 petition for judicial review in a district court in  
39 Travis County.